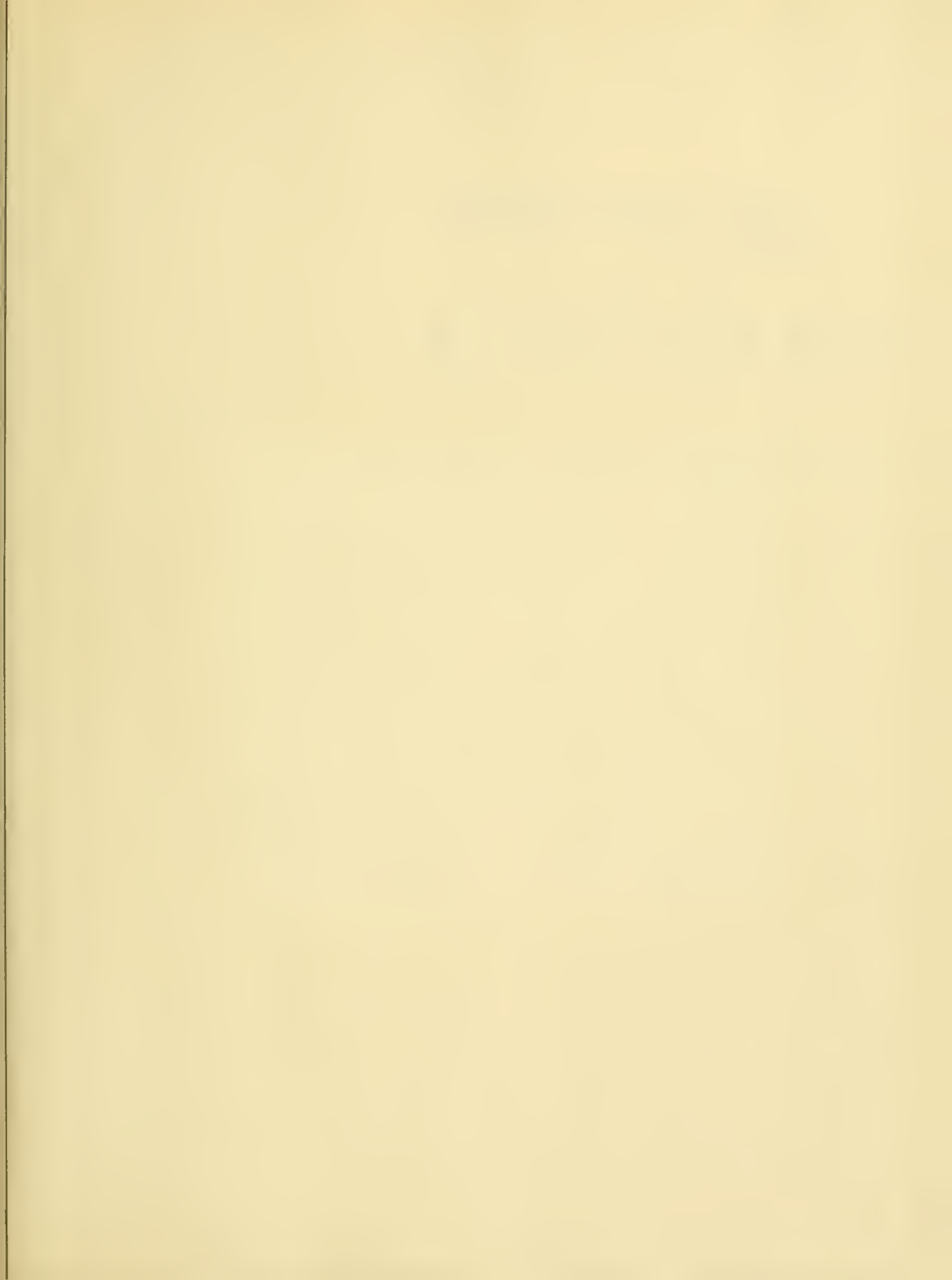


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A preschool child tries out the nursery school piano keys. A child's natural curiosity, when stimulated by the environment and encouraged by the adults in his life, is an important factor in the development of the intellect, as is pointed out in the article beginning on page 8.

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In recent years, the development of special nursery schools and day care centers for mentally retarded children has spread throughout the country. When children are enrolled in such schools and centers at the chronological age of 3 or 4, in mental age they are often well below 3 years, usually the lowest age of admission to nursery schools for children of normal intelligence. This fact faces administrators and teachers with important questions not only about what modifications in the traditional preschool program are necessary but also about what differences in adjustment and emotional reaction can be expected between mentally retarded and normal 3- and 4-year-old children.

Nursery school educators have long stressed the importance of giving the child a chance to enter the school gradually, usually in the company of his mother. However, nursery schools for retarded children, including those that are highly rated, often start right off by transporting the children from home to school, paying little or no attention to the possible emotional effects of separating them so suddenly from their parents.

In pointing out this discrepancy, we are not opposing nursery schools or day care centers for retarded children, which we regard as necessary, but we are suggesting that such programs need to examine their ways of operating. Again, in focusing attention on separation reactions in young children we are not suggesting that such reactions are undesirable—quite the contrary, for it is part of normal emotional development for a child to react to separation from his parents by protesting. We are maintaining that retarded children may need special help in expressing their emotional reactions and adjusting to separation as steps toward developing a sense of autonomy and identity.

Specialized nursery schools and day care centers provide desperately needed relief for parents, especially for parents of moderately and severely retarded children. If one waited for the mental age of 3, the moderately retarded child would be at least 6 years old before admission. From the standpoint of the child's needs, a stretched-out period of complete dependency on confused and emotionally ambivalent parents can produce unnecessary infantilism. The retarded child may well need the stimulation of an objective outsider to develop his potentials.

We are concerned here with the psychological problems of mildly retarded children, who presumably have the same needs as other children for healthy emotional development. In the past, mildly retarded

SEPARATION REACTIONS

in young, mildly retarded children

JANE W. KESSLER • GRIDTH ABLON • EDITH SMITH

Children were rarely diagnosed until they reached school age, but today specialized clinics using refined diagnostic methods are locating more of them in their earlier years.¹ Early diagnosis is generally assumed to be advantageous to the child, but this is true only if it is followed by a therapeutic program. By and large, because of the child's intellectual deficit, the recommended therapy is special education. However, identification of a mental deficit should not blind us to the overall needs of the child.

Many people today are questioning whether the practice of enrolling children of normal intelligence in nursery school at the age of 3 is based on sound child development theory or whether it is simply a matter of tradition. However, the rationale underlying this convention is worth examining. Anna Freud,² in a psychological exposition of the desirable prerequisites for nursery school entry, has described the child's readiness for a nursery school experience in terms of the child's status along certain lines of development. On the line toward bodily independence, she suggests that the child should have reached the stage where he can enjoy the kind of food or drink given in nursery school and is able to use the school toilet.

On the line from egocentricity to companionship, Miss Freud suggests that the child should be able to relate to other children as helpmates in carrying out a

desired task, such as playing, building, or destroying. Thus, although the normal 3-year-old is selfishly motivated, he responds to what he sees other children doing and is able to engage in some cooperative play. He is at the beginning of the stage when "play material serves ego activities and the fantasies underlying them"² and is well beyond the stage when all objects are handled in the same way—everything is an object to mouth, twirl, or throw.

Anna Freud does not discuss language development as such. The nursery school teacher, however, expects a child to be able to express his wants in words and to comprehend simple verbal directions and explanations. The child who is ready for nursery school can understand the words "going to school" and "going back home." Part of the time, at least, he recognizes that separation from his mother is temporary and he knows what to expect when she leaves. However, the normal 3-year-old has a shaky sense of time that is more dependent on his feelings than on the clock.

The child's status on the developmental line from total dependency to self-reliance is crucial in determining the nature of his reactions to separation. Anna Freud maintains that ideally the child entering nursery school should have reached the stage of "object constancy," at which the absence of the external object—in this case, the mother—is replaced by a remembered image that remains stable regardless of the child's feelings. At this stage, the child knows that his mother exists independently of his im-

Based on a paper presented at the 1968 annual meeting of the American Orthopsychiatric Association.

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mediate perception and that she will reappear no matter how frustrated or angry he may feel at the moment. When the child appreciates his mother's independent and constant existence, he recognizes his own identity and autonomy. This enables him to retain his self-control in his mother's absence. This sense of "I am I wherever I may be" follows the awareness of differences between "me" and "you."

Such individuation first appears in the child in the form of learning the boundaries and powers of his own body. This is followed by a process of learning to know his own mind. Gradually the child corrects his first assumption that as he thinks, perceives, and feels, so does the rest of the world. Discovery of such differences helps him to become aware of himself as a distinct person and to imagine others going about their everyday affairs even when he is not an eyewitness. When a child has reached this point, separation from his mother does not signify permanent loss to him.

Nursery school teachers expect the normal 3-year-old who has reached the stages of readiness described by Anna Freud to show some separation reaction at the beginning of school. It would indeed be surprising if such a young child had no reaction to finding himself alone in a strange place with strange people. Any adult who has been suddenly transported to a foreign country can understand such feelings. People are sympathetic to the phenomenon of "culture shock" in adults, but surprisingly obtuse in recognizing the feelings that separation brings to a young child. To quote Anna Freud:

In the not-too-distant past it was assumed that a child who had reached the age of 3 years 6 months should be able to separate from his mother on the first day of entry at the outer door of the nursery school building and should adapt to the new physical surroundings, the new teachers, and the new playmates all in one morning. A blind eye was turned toward the distress of the new entrants; their crying for their mothers, their initial lack of participation and cooperation were considered of little significance.

Possibly, the teacher becomes somewhat obtuse so that she will not feel guilty for making the child unhappy. Sometimes the child entering nursery school shows no sign of sadness; he may appear excited or overjoyed. In a detailed case report, Janis describes the initial euphoria and later separation distress of a normal 2-year-old girl starting nursery school. Janis interpreted the child's euphoria as a denial defense that temporarily enabled her to ward off separation anxiety. Anna Freud, in discussing similar observations, suggested that the delay in reacting to separation was due to the young child's slow intellectual grasp of the situation.

But how do retarded children react to separation from their mothers? In view of their slower intellectual grasp, do they experience separation anxiety in greater or lesser degree than 3-year-old children of normal intelligence? Do they show such anxiety in different ways and at different times? A study made by one of the authors of this article, Gridth Ablon, at Case Western Reserve University sheds some light on these questions.⁴

Retarded children's reactions

The experimenter compared two groups of 18 children each with mental ages from 19 to 32 months who had not attended nursery school. Children in one group were mildly retarded with IQ scores ranging from 58 to 83 and chronological ages from 27 to 36 months. Children in the other group were of average intelligence with IQ scores ranging from 91 to 110 and chronological ages from 18 to 32 months. Each child was observed individually for four 15-minute play sessions. In the first and third sessions, the mother was present, in the second and fourth she was not. Various measures were made of the "level of play" that the children demonstrated in the four sessions. Interestingly, both groups played at the same level when their mothers were present. Separation from the mother led children in *both* groups to regress in level of play and to become much more rigid.

The study revealed a difference in verbalization between children in the two groups when the mother was absent, although it was not designed to investigate this difference systematically. When the mothers were present, the children's verbal responses were mainly short direct questions—for example, "what is that?"—and many children in both groups were silent. However, when their mothers were absent, normal children seemed to be able to use words

constructively to help master their anxiety. For example, several children asked "where is my mother?" or "will my mother wait for me?" Others asked the experimenter the kind of questions they had previously asked their mothers. In contrast, the retarded children appeared nearly overwhelmed by anxiety. Many of them cried and were unable to talk. While both groups of children appeared to feel threatened by the absence of their mothers, the children with average intelligence seemed to have mechanisms for coping with the problem, but the retarded children did not.

Ablon's observations may explain why teachers of retarded nursery school children have little to say about separation anxiety. Because such children do not give the usual verbal clues to their feelings, teachers often attribute the regressed behavior to the mental retardation itself, and the children's aimless running around to hyperactivity.

Play groups

These observations have led the Mental Development Center at Case Western Reserve University to establish play groups for retarded children as a transitional step to nursery school. The children enrolled are from 3 to 5 years in chronological age and from 1½ to 2½ years in mental age. Diagnostically, the mental retardation represented a variety of organic, cultural, and unknown causes. However, we did not include any children with Down's syndrome in our play groups, because these children seem to socialize relatively well in normal nursery school and a variety of other situations and we did not think they needed this special program.

Groups of seven or eight children meet three times a week for an hour and a half. In the early weeks, the mothers remain in the play room, later they move to an upstairs waiting room, and after several months they leave the building altogether. When the reasons for this gradual separation were explained to the mothers, they said such a plan was not needed because their children would not miss them and would probably not even be aware that they were gone. A few mothers wanted to make a "clean break" because they feared that their children would cling to them indefinitely.

At first, almost all of the children became engrossed in exploring the toys and physical surroundings and paid little attention to their mothers or the teachers. As one teacher put it, they seemed to "float over the surface of the school," showing only brief

attention to certain manipulative aspects of the play materials and having little contact with the adults or with one another. Their interest in any toy or activity was short-lived and they soon became excited into a frenzy of giggling, screaming, and aimless running about. However, as the children became more familiar with their surroundings, they sought out their mothers more frequently, particularly when frustrated or upset. For instance, if a child became angry with the teacher, he might run to his mother for comfort or to vent his rage on her. There were, of course, many individual differences. For example:

Mark was an early clinger. He began his struggle between mastery and dependence by standing helplessly in the hall, unable either to go to his mother in the next room or to return alone to the playroom. When he was reassured that it was all right for his mother to stay with him if he wished, he accompanied her back to the playroom. But once there, he ignored her completely. After the teacher worked with him for 4 weeks, showing him pictures of his mother going upstairs and teaching him to say "Mommy stay" and then "Mommy upstairs," Mark was able to manage on his own.

Larry, on the other hand, initially showed no clinging behavior. Larry was the most immature child in the play group when he entered at a chronological age of 45 months and a mental age of 20 months, with an IQ of 45. His language was limited to a half-dozen single words and his activity consisted of running around, shadowing, and mimicking some other child who temporarily caught his attention. He seemed oblivious to his mother most of the time, but panicked if he could not spot her at the moment he felt he needed her.

In the play group, Larry developed more independent actions, more eye contact, and some ability to communicate simple ideas. He even asked another child, "Want a spoon?" He examined himself in the mirror almost every session. It was instructive to watch Larry's sense of identity develop along with his use of language and his ability to tolerate separation. Toward the end of the school year, he would still get anxious after he had been absent for any reason and would need his mother's presence in the playroom.

A disguised form of separation reaction was shown by two other children—resistance to leaving the school at the close of play group sessions. Although such a show of reluctance might have been interpreted as a genuine preference for the school over the home and a rejection of the mothers, the teachers were suspicious because of the children's general air of anxiety. They seemed to be teasing their mothers by defiantly demonstrating, "I don't care anything about you." Their behavior suggested a reversal of roles: they felt they were doing to their mothers what their mothers had done to them. These children seemed afraid of any change in or out of

the play groups. They were the only children who needed their mothers to come back to the playroom when the other mothers moved upstairs. Other children sought mastery of the situation by assuming an active role at the beginning of separation, that is, leaving their mothers at the new place instead of letting their mothers leave them.

Throughout the year, a social worker met with the mothers three times a week while the children were in the play groups.

The objectives of these sessions were to help the mothers (1) recognize and deal with the child's feelings, (2) learn about their own feelings and how they might be communicated to the retarded child, and (3) learn practical techniques of management and home teaching. Often the mothers were surprised to realize the strength of their child's attachment to them—a realization that seemed to open up new doors to those mothers who had felt that their own child had little use for them. Whether these mothers had originally rejected their children was beside the point; the social worker was concerned only with establishing or reestablishing bonds of communication and caring. As a mother became aware of her child's unspoken feelings and their effect on his behavior, she became better able to help the child identify his emotions and to give him names for "sadness," "anger," "loving," "excited," "scared," and so on. She learned the value of talking to the child, explaining things to him, and preparing him for events to come—even when the child did not ask any questions.

The mothers observed how the play group staff related to, worked with, and really enjoyed the children, accepting them as worthwhile, teachable persons with the same kind of feelings and defenses as everyone else. The group structure was also a great advantage to the mothers who gave support and

help to one another. They often found it easier to recognize in someone else their own reactions of depression, guilt, and discouragement in having a retarded child. On the other hand, the mothers could convince one another that each had a vital role in making her child happier and more effective. The mothers developed strong ties to each other and were reluctant to leave the group at the end of the year.

Role of the teacher

We provided one teacher for every three children since the children did not really represent a group. The teachers saw their roles in working with children who are not ready for the usual nursery school program as a challenge, not as mere babysitting. In organizing the teaching procedures, they looked at separation from a theoretical point of view to determine the ingredients a child needed for mastery. They realized the child needed to become aware of himself as distinct from his mother and able to maintain a constant image of her existence independent of his needs and their fulfillment; and that he needed to see the teacher as distinct from his mother, yet sharing the characteristic of being a safe, protective adult who could also help fulfill his needs.

The teachers made special efforts to identify the child to himself and the other children by showing him his own photograph, saying his name, and verbally calling attention to what he was doing: "Mary is digging." "Mary Beth is hiding." Staff members drew pictures of each child and his mother. At first the children ignored the pictures, but they gradually gave verbal responses such as "Mommy" or "I know it." When the mothers moved to the back of the room, the teachers encouraged each child to show his mother something. In a few cases, the child had to hold a teacher's hand to walk across the room. During the last phase of the separation, the teacher worked to help the children form a concrete image of where their mothers really were and to use words to express their sadness and anger. The teacher felt that the interpretation reached the child if he listened to them or looked at the picture. Several children changed their behavior—tangible proof that the teacher's communication was successful.

As the children separated from their mothers, they turned more to the teachers for comfort and aid. The teachers were able to use their new relationships to help each child socialize with other children.

When the children first enrolled in a play group they had little ability or desire to relate to each other

Retarded children progress from solitary to parallel play as will this child who sits alone in a corner of the nursery school.



as helpmates. Even the several children who had learned superficial manners did not form constructive relationships. They treated peers and teachers as inanimate objects in their environment. They scattered throughout the room, showing little curiosity about each other and ignoring remarks that were not made directly to them. When another child infringed on their play area, they responded either by withdrawal, overactivity, or vocalized complaints directed to no one in particular. If they bumped together, the children often struggled over possessions and needed a teacher's mediation. While mediating, the teacher supplied similar objects or equal divisions that would yield some parallel play. She also suggested verbalizations like "help me," "no, that's mine," or "stop it." When playing with one child, the teacher always looked for a way to include another nearby child and thus build parallel play into something more social. However, the teacher usually had to provide suggestions. "Mary Beth, Denise is calling you on the phone." "Jon's the daddy; he needs some coffee." "You and Larry go get dishes for the table." The children needed direction not only in making the first approach in playing with each other, but also in responding appropriately. The children seemed to get great satisfaction from the suggested forms of play, which they repeated session after session.

Some basic steps

The success of the play group program has convinced us that a mother and her retarded child may best be helped in a group setting. Counseling the mother alone in the office or in the home does not suffice. Although we readily acknowledge the differences in bringing up retarded children and normal children, we feel that any program for retarded children should build in an approximation of normal events without skipping basic steps.

In our play groups, we stress helping the child develop object relationships, to establish first an awareness of self with feelings, capacities, and desires, and then a similar awareness of mother, teacher, and peers. From this viewpoint, the total absence of any separation reaction in a child seems ominous. Therefore, we attempt to evoke the expected normal response from the children. We enlist the mother as an active collaborator, since we are trying to strengthen the mother-child relationship. We have tried to avoid the establishment of what might be called "splinter skills"—that is, oral recitations,

rituals, and other behavior forms that have no meaning to the child.

Our observations have indicated that when mentally retarded children have achieved the ability to separate from their mothers and to adapt to a group, they are ready to learn skills and to profit from an educational program designed to compensate them for their cognitive deficits. Possibly, the dependency and "outer-directedness"⁵ that is characteristic of so many retarded persons results from early failure to establish a basic sense of autonomy and identity.

The play group program is probably a luxury that cannot be widely replicated. It can only serve as a demonstration of certain principles. We believe that we have demonstrated that young, mildly retarded children do have separation reactions that deserve attention. Even with the severely retarded child, the teacher should anticipate some regression of behavior and try to minimize the effect of the strangeness by having the mother present for an initial period of time. The mother should be well acquainted with the teacher and participate in the program so that she can talk about it at home. In turn, the teacher should know about the other members of the child's family, his pets, and home activities so that she can discuss them with the child at school. The curriculum should place considerable emphasis on "mother"—where she is now, what she is doing, and the reunion with her.

A child often disguises or delays reactions to separation by refusing to cooperate with the teacher. If this happens, it may be wise to bring the mother back into the nursery school. However, the child may be able to master his feelings if the teacher helps by recognizing and accepting them. Perhaps what is most important is that the teacher should not be reluctant to have the child show that he misses his mother. To miss his mother is a normal reaction in a child and casts no aspersions on the teacher's skill with children or her nursery school program.

¹ Oppenheimer, S.: Early identification of mildly retarded children. *American Journal of Orthopsychiatry*, October 1965.

² Freud, A.: Normality and pathology in childhood: assessments of development. International Universities Press, New York, 1965.

³ Janis, M. G.: A two-year-old goes to nursery school: a case study of separation reactions. National Association for the Education of Young Children, New York, 1965.

⁴ Ablon, G.: Comparison of play of retarded and average children. Unpublished doctoral dissertation, Case Western Reserve University, Cleveland, Ohio, June 1967.

⁵ Zigler, E.: Research on personality structure in the retardate. In International review of research in mental retardation. Academic Press, New York, 1966.

EARLY CHILDHOOD EDUCATION

FOR WHAT GOALS?

MILTON J. E. SENN, M.D.

● There is today a cleavage between educators of young children who favor educational practices based on concepts of the child in relation to his *whole* emotional-cognitive development and those who favor practices aimed only at developing certain measurable skills defined as "intelligence."

In my opinion the sane perspectives on the hierarchy of values have been turned on end. We are now urged to believe that highly structured, mechanical, and rigid practices in teaching are superior to those that are flexible, child-experience oriented, and focused on human relationships. We are being led to expect both immediate and lasting results from programs aimed at speeding up the learning in the youngest minds. Emphasis on the intelligence quotient as the measure of achievement continues despite strong evidence that questions the validity of this practice.

Obviously the changing nature of societies forces a reconsideration of how to educate a new generation. The Russian launching of Sputnik in 1956 triggered a near phobia about making American minds equal, if not superior, to those of our cold war competitors. More recently the civil rights movement has moved us as never before to take stock of our human resources. Now there is a readiness to accept the long-held premise of persons in the field of child development that the beginnings of waste start in the early years, and research in the education of young children is proliferating.

We have had few great educational theorists in

the United States other than G. Stanley Hall, John Dewey, and William James to lead the way. For the most part we have looked to foreign countries for basic theories about the nature of man, his attributes and his needs and for concepts of how these are to be dealt with educationally—to such geniuses as Jean Jacques Rousseau, John Locke, Henry Pestalozzi, Friedrich Wilhelm Froebel, Maria Montessori, and of course Sigmund Freud. To this list has recently been added the contemporary Swiss epistemologist Jean Piaget, who has had a profound influence on American psychologists and researchers in child development since the early 1950's.

Piaget's influence

Piaget and his colleagues in Geneva are primarily recognized for the work they have done in the field of cognition, although Piaget has been mostly concerned with the nature of knowledge and with the structures and processes by which it is acquired. His discoveries that experiences in the first 5 years of life are vital and long lasting and that infantile sensory-motor coordinations are forerunners of the form and content of adult thought substantiate the theories of Freud. While Piaget is informed about Freudian theories and has long realized the importance of emotional processes in learning, he has said that time has limited his considerations to study of *intellectual development* and that he would leave to others the consideration of *feeling states* and their relationship to learning. However, few of his disciples in the field of experimental psychology have been inclined to integrate their research on cognition with research on personality development.

Piaget views the growth of the structures of know

Condensed from the first Evangeline Burgess Memorial Lecture presented at Pacific Oaks College and Children's School, Pasadena, Calif., April 3, 1968.

ing as proceeding over time, beginning in early infancy and ending in adolescence.¹ Not only is there a distinct beginning and ending in the schema he presents, but there are also certain *critical periods* along the way. Human intelligence (or knowing) begins with the phase of sensory-motor responsiveness. The infant is equipped by heredity and constitution with reflex patterns for reacting to touch, vision, sound, and kinesthesia; his behavior is shaped by external demands imposed by the environment; response to these demands goads his mental growth.

As he assimilates his experiences, the baby learns strategies for coping with both external and internal demands, and with time he organizes the information he has acquired into systems. By the end of his first year the child is able to construct a theory of the world that transcends direct sensory experience, as when he appreciates the existence of an object he cannot see and develops skill in searching for the unseen. By the time he develops language, which is dependent on his sensory-motor functions, he is more manipulatable in thought and more susceptible to social correction. We say he is able to "internalize his actions," to use his mind and proceed from perception and manipulation to reflection.

The phases of intellectual development follow each other, not in strictly chronological fashion, but in a sequential and orderly manner from early infancy into early adolescence. Piaget believes that these phases may be accelerated to some extent by manipulating the environment but that such manipulation will only be effective up to a certain point. The environment *is* important but only as a child is able to pay attention to it, and this ability depends on the degree of assimilation which has taken place. However, the greater the *variety* of experiences a child copes with, the greater becomes his ability to cope.

Piaget never points to any practical implications of his work. Aware of what some of his followers are doing in the application of his studies to the education of young children, he has issued a timely warning by inquiring, "What is learning for—to know a certain *number* of things, or to be capable of creating or inventing new things?"

There continues to be much unclarity in the minds of many of Piaget's adherents about the meaning of the term "cognition." Piaget himself, pointing out that his theories are unfinished, continues to change his emphasis, concepts, and terminology.

Cognitive psychologists interested in infant behavior and learning have also found encouragement

in the research of other scientists who have studied babies reared in different environments. René Spitz and others, for example, have reported harmful effects of impersonal care and understimulation suffered by babies reared in foundling hospitals.² Although the emphasis in such research was at first on affect deprivation, later investigators have reported damage to cognitive functions as well.³

Early stimulation

For the past several years there has been a burgeoning of investigation into the physiological, psychosocial, and intellectual deficiencies resulting from understimulation and of efforts to prevent and ameliorate deficiencies by sensory stimulation. Studies of sense organ stimulation in newborn infants have had special appeal to investigators. Often this research has resembled the experiments conducted in Russia for over a decade, in Moscow under A. S. Louria and in Leningrad under the Pavlovian-trained pediatrician Nicholas Krasnagorski. The American investigators, like the Russian, have found that a baby not only changes his physiological reflex responses after sensory stimulation, but that he learns to change his behavior if he feels rewarded by the process of stimulation. For example, newborn babies learn how to change their rate of sucking and how to move a mobile with their toes when pleasurably stimulated by sight and sound. The inference from such findings is that babies can learn more than we realize if they are taught by techniques that stimulate the nervous system.

The Russians believe that through conditioning they can overcome the ill effects of prematurity very early in infancy. While this theory has never been validated elsewhere, many American cognitive psychologists believe that through early stimulation of the central nervous system of normal babies, they may speed up their intellectual development so that by the time the children are 4 years old they will be greatly beyond the normally expected level. Since it is commonly believed that by age 4 a child has attained half of his final intellectual capability, the race seems to be on not only to have American children attain their full intellectual potential before adolescence, but to keep it increasing to a higher degree than is normally attained.

Some cognitive psychologists believe that future generations can reach 30 IQ points ahead of the present generation through better management of their early environment, beginning in infancy. Yet the

definition of intelligence remains unclear. Moreover, there is no agreement on the details of *how* and *when* to manipulate the environment.

In reviews of the research on stimulation of infants, one rarely finds words of warning or descriptions of any harmful effects of early stimulation. But the research of Burton L. White of Harvard points in that direction.⁴ In studying institutionalized infants, he found what Spitz and others had described: delays in motor response due to lack of visual stimulation. In attempts to find ways of preventing such deficiencies, White studied a group of 6-day-old normal babies in a hospital. He saw that they got more physical handling, more opportunity to look around, and more bright objects to see than is usual. He found that this special stimulation upset the babies; they cried a lot and paid less attention to their surroundings. However, when he provided similar ministrations to babies 2½ months old, favorable responses resulted; these babies smiled at objects, vocalized, and seemed happier than unstimulated controls. Thus, the timing and amount of external stimulation are important.

The Russians report that although a newborn baby may be helped to mature more rapidly by conditioning, all newborns do not respond favorably to such treatment. This is because there is a basic difference in equipment in each individual, which makes the *timing* of the conditioning important. As one would surmise, the more mature babies respond more favorably than the less mature. Nevertheless, in Russia all normal newborns in hospital nurseries are stimulated visually and aurally; "teachers" sing to them at prescribed times each day, dangle colored rings before their eyes, and shake a tambourine next to their ears.

John L. Fuller, senior staff scientist at the Jackson Laboratory in Bar Harbor, Me., has also substantiated the theory that timing and quality of stimulation are important. Experimenting with dogs, he discovered that animals that had been isolated and deprived of sensory stimulation from birth could be helped to overcome their deficits only if the changes in their environment were made gradually and in a way that permitted their sensory-motor capacities to adapt slowly. When the transition from the depriving to the stimulating environment was made too rapidly, the adaptive mechanisms were overstrained and the dogs became especially fearful.⁵

Fuller described another important aspect of appropriate stimulation when he reported that only when the stimulated animals' stress was reduced by stroking and handling were they able to make any contact with other objects, whether toys or humans,

without irrational fear. These observations tend to verify the conviction of many teachers that contact with humans is more important than stimulation from impersonal objects and that human relationships are the primary factors in helping children to learn.

Other psychologists have found that children who have been deprived and are abruptly exposed to new stimulating experiences do not learn readily, because they become excited and have less control over their impulses than usual.

Another researcher speaks to the question of appropriate quality of stimulation when he describes his longitudinal studies on infants from 4 months to years of age. Measuring how much babies in the first year of life perceive and understand of their environment, Jerome Kagan of Harvard University observed differences between babies from different socioeconomic backgrounds. The *distinctiveness* of the stimulation, more than the *amount* of stimulation, marked the difference between children from middle and lower socioeconomic groups. Kagan has concluded that learning should be fostered in infancy through a *distinctive* (not yet clearly defined) stimulation provided by parents and that all parents need education about this process. He also believes that the classroom environment for children must be designed to fit the child's needs, and that these needs vary according to the child's early rearing.⁶ Thus, inappropriate stimulation, as well as overstimulation, may be as disastrous for children as understimulation.

Preschool programs

Awareness of the great difference in learning between slum children and those reared in more affluent circumstances led to the founding of Project Headstart in 1965. Unfortunately, it was begun as a crash program, without sufficient time to recruit well-trained, experienced teachers. Many of those who accepted teaching and administrative roles received only short periods of training before they began to work. Often they did not know the characteristics of children aged 3 to 5 years of any racial or socioeconomic background, nor how to fashion appropriate learning opportunities, and they were unprepared for the upsurge of their own feelings in dealing with the children brought to them. Therefore, many of the Headstart classes have failed to give children enough of the kinds of experience they most needed.

This is not to say that gains have not resulted from Headstart. Although the greatest gains may

come from the early recognition of disease and the correction of physical defects in children who otherwise would not have received any medical care, children may also have gained educationally by becoming better informed about themselves, their neighborhoods, and the world around them. Too frequently, however, Headstart programs have failed to teach children what they were ready for, such as a better use of language for communication. On the other hand, in a few sophisticated urban communities, the Headstart program has become a pawn in the struggle between advocates of differing methods of early childhood education.

Some critics of the standard, play-oriented nursery school approach have recommended more structured and didactic methods of teaching, not only for Headstart but for all early childhood education. A program originated by Siegfried Engelmann and Carl Bereiter at the University of Illinois concentrates on teaching children certain special *items* which these experimenters believe every child must know when he enters first grade. The program has three distinctive characteristics: (1) a high ratio of teachers to students, (2) reliance on drill, and (3) learning by rote. Children are made to repeat after the teacher the names of objects, numbers, and descriptions of various items held in front of them. No deviation of response is permitted; there is always only one right answer. The children are asked to answer in unison as well as individually. There is little tolerance or time for an original idea or an association spontaneously expressed. The conditions are conducive neither to curiosity nor to learning the connections between the things recited and things experienced.

This method of teaching will be remembered by many older persons as the kind they experienced in school. However, it differs in one respect in that the young pupils are not expected to sit impassively with hands folded. The children are encouraged to recite as a group with simultaneous loud clapping of hands and other rhythmic movements.

In watching any of these classes, one is impressed with the seriousness of the work at hand. The emphasis in learning is on work, not play, and on making everything count as if time needed to be conserved. Disapproval of mistakes is expressed not only in strong words but occasionally by slapping a child's hands, as if to emphasize that a person must feel guilty when he makes mistakes and that errors are similar to misbehavior in being punishable.

It is not easy to determine the effects of this kind of teaching on children. Engelmann and Bereiter



A group of children in a Headstart program react with varying degrees of interest to the book the teacher is showing them.

have been pleased that their children learned to speak in sentences, progressed in arithmetic, reading, and spelling, and in general increased their IQ levels.⁷ There are reports that the children have made gains in psycholinguistic ability. There are also reports that the children are very often tense and frightened and respond automatically. Some child development specialists doubt whether the results of rote learning will carry over into the later years of schooling and suggest that the children may even develop a fear of and distaste for school.

The question arises as to whether children taught by these methods have really learned to think, to reason, and to conceptualize, or merely to parrot unquestioningly whatever they are told by authoritarian teachers.

In an experiment at the University of Florida, mothers of very young babies are being taught in well-baby clinics how to use toys so that their children will learn concepts of size, relationships, and color. This program is similar to one in Russia wherein mothers are taught how to play with their children and to use toys recommended by the polyclinic staff. The Florida experimenters, like the Russian, emphasize attention to small muscle movements, exercises, and body massage as ways of producing kinesthetic stimulation and fostering mental development. Here again, the emphasis seems to be on how to get the children to learn *more* and to develop various *skills* without any attempt to foster their creativity or individuality.

Teaching the use of toys in such a didactic man-

ner resembles the methods of Montessori. This Italian physician-educationist worked with slum children 3 to 7 years of age in a day-care center in Rome in the early part of this century. She invented educational toys and used them in didactic teaching to help children develop their intelligence. She also sought to inculcate discipline and good habits of study. But in contrast to some present-day American educators, she was also concerned with the cultivation of independence and curiosity as well as persistence in learning.

The Montessori system never really got started in the United States until about 10 years ago, when it suddenly spread across the country. However, there have been so much unorthodoxy and deviation from the original methods that it is rare to find two Montessori nursery schools in which the methods are applied alike. The revisionists have tended to favor modification in the use of the equipment, flexibility in programing, and more free play.

What the long-term effects of these various techniques will be remains unclear. Those researchers who are providing more stimulation to children have not demonstrated that sensory stimulation enhances the use and understanding of symbols, which are necessary for the development of a sense of meaning. Those who use teaching machines acknowledge that unless wisely used such products of educational technology could destroy initiative and individuality, "making all men alike and not necessarily alike in nice ways."

Barbara Biber of the Bank Street College of Education has pointed out that "the method, through its effects on attitude and therefore on motivation, becomes a secondary determinant of how far the original learning goal will be realized."⁸

Defining goals

Program planners today in discussing appropriate goals for early childhood education show little understanding of *the difference between intelligence and intellect* and to which of these qualities educational efforts should be directed.

The historian, Richard Hofstadter of Columbia University, however, has given much thought to the differences between intelligence and intellect. "Intelligence," he says, "is an excellence of mind that is employed in a fairly narrow, immediate, and predictable range. Intellect on the other hand is the critical, creative, and contemplative side of mind. Whereas *intelligence* seeks to grasp, manipulate, re-

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order, adjust, *intellect* evaluates and looks for the meanings of situations as a whole. It implies special sense of the ultimate value and the act of comprehension. Socrates struck its essence when he said that the unexamined life is not worth living."

In assessing the effects of programs, emphasis too often has been on measuring cognitive development or other learning on the basis of changes in IQ scores. Many of the new teaching techniques do seem to bring about significant increases in IQ scores. Others, however, do not effect gains as measured by tests, yet do help disadvantaged children develop skills they would not otherwise have. This discrepancy between test results and achievement has led clinical psychologists to reappraise the standard tests of intelligence and to attempt to design substitutes that take into consideration the tested child's cultural heritage and areas of deprivation and that can detect gains in ability to learn as well as changes in IQ.

Martin Deutsch of the Institute of Developmental Studies, New York City, in discussing the relevance of intelligence testing to work with socially deprived children, warns that the current faith in test result tends to overshadow another worthwhile source of evaluation—reports of individual teachers. He points out that teachers stimulate *curiosity* and *initiative* in children, two characteristics that the usual testing in schools does not measure.

In early childhood education, as in all child care and rearing, we should be concerned with the "whole child," the total self, not just the development of certain mental characteristics or the learning of skills. The conception of the whole child need not be as generalized, vague, or overflowing with inspirational platitudes as some people have made it. The "whole child" represents a composite organism, the physical, emotional, and social self that learns through a variety of processes, cognitive learning being only one

important component and one which also involves feelings and emotions.

When I say I believe in helping children experience joy and happiness in learning, I do not mean protecting them artificially against the crises of life or from all experiences of fear, anxiety, and unhappiness. When I say I want children to feel free to ask questions, to explore, to experiment, to be spontaneous, I am not advocating license in a classroom that is unsupervised or led by a teacher who is incompetent or irresponsible. I expect teachers to be informed about appropriate curricular materials, but also to know how to incite the deep interest of children through their teaching skill and their relationship with pupils, without resorting to pedagogical tricks. I expect educational programs to help children find themselves as individuals—learners, thinkers, doers, persons with feelings, increasing clarity as to their identities, and appropriate roles in life. Such programs can be based on sound experimental studies of learning and teaching and the results evaluated by rigorous methods that go beyond the measurement of changes in IQ.

Herbert J. Muller puts it this way: "What is needed, under any name, is the view of the biological whole man, a view in which we can make out the full value of the rational, but also the necessity of the nonrational—feeling, sentiment, desire. The activities of the higher motor centers, known as the exercise of reason, are the most advanced point in man's development, the finest means of adaptation; but they do *not by themselves* actually run man. They belong to a nervous system, which, in turn, is subordinate to the system of needs and purposes that is the whole organism."¹⁰

It seems to me that, at the very least, our goal should be the enhancement of all those factors that inevitably interact and foster the appropriate development of all parts of a child as he moves from infancy to childhood, then to adolescence and to adulthood. This will include the environmental, emotional, social, psychological influences as well as the cognitive and all other elements involved in learning. Above all we should avoid the myopia of fragmentation wherein understanding of the whole organism is obscured by focus on a part.

Children do need to learn how to adapt to a rapidly changing world, but a speedup in their learn-

ing, in skill proficiency, does not guarantee ability to cope with life at any tempo. Too frequently today the emphasis is on speed, on hastening learning. Children are denied time to reflect, to cogitate, to dream. I believe this denial hinders the development of the intellect as distinguished from development of intelligence.

By concentrating on intelligence and discouraging intellect, current educational methods may lead to the unexamined life deplored by Socrates. Yet without the ability to examine life, the individual is impoverished and society is deprived; it could be that without the ability and the will to examine life we may stop living.

What goals are we striving for in education and child rearing? My personal hope is that our passion for mass education will be founded primarily on belief in the desirability of developing the mind, and on a pride in learning and culture for their own sakes, rather than on political or economic benefits; and having set that goal, that we will implement it by doing whatever is necessary, so that we may finally realize the kind of education we have idealized in words for over 200 years.

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³ Goldfarb, W.: Emotional and intellectual consequences of psychologic deprivation in infancy: a re-evaluation. *In* Psychopathology of childhood. Grune & Stratton, New York, 1955.

⁴ White, B. L.; Held, R.: Plasticity of sensory-motor development in the young infant. *In* The causes of behavior: readings in child development and educational psychology. Allyn & Bacon, New York, 1966.

⁵ Fuller, J. L.: Experimental deprivation and later behavior. *Science*, December 29, 1967.

⁶ Kagan, J.; Lewis, M.: Studies of attention in the human infant. *Merrill-Palmer Quarterly*, April 1965.

⁷ Bereiter, C.; Engelmann, S.: Teaching disadvantaged children in the preschool. Prentice-Hall, Englewood Cliffs, N.J. 1966.

⁸ Biber, B.: A learning-teaching paradigm integrating intellectual and affective processes. *In* Behavioral science frontiers in education. John Wiley & Sons, New York, 1967.

⁹ Hofstadter, R.: Anti-intellectualism in American life. Vintage Books, New York, 1966.

¹⁰ Muller, H. J.: Science and criticism. Yale University Press, New Haven, Conn. 1964.

A PSYCHOTHERAPEUTIC AIDE IN A HEADSTART PROGRAM

I. THEORY AND PRACTICE

MICHAEL P. ANDRONICO • BERNARD G. GUERNEY, JR.

● The purpose of Project Headstart is to help children from disadvantaged backgrounds achieve intellectual levels nearer to other children by the time they enter kindergarten. This faces the programs not only with the necessity of motivating these children to learn, to make up for deficits in intellectual stimulation in their homes, but also with the problem of dealing with many children whose learning potential is hampered by emotional difficulties.

For a number of reasons children from lower socioeconomic backgrounds are difficult to reach through child guidance clinics. Headstart nursery school may be a much more realistic setting in which to provide psychotherapeutic treatment for disadvantaged children than a conventional child guidance clinic.

But a shortage of available professional persons in the mental health field precludes the extensive use of professional persons for direct psychotherapy with children in a Headstart program.

On the theory that nonprofessional persons may successfully serve as child psychotherapeutic aides in Headstart projects, the Riegel Ridge Paper Foundation Headstart Project in Milford, N.J., has experimented with the treatment of emotionally disturbed children through a nonprofessional neighborhood worker who had previously been trained in the principles of play therapy through a "filial therapy" program.

In its unmodified form, filial therapy is a method whereby parents of emotionally disturbed children work with their children at home for brief periods of time, using the principles of child-centered (Rogerian) play therapy^{1, 2} taught to them by professional therapists.

Parents learn these principles in groups of five to eight, which meet regularly for 2 hours a week. The aim is to provide the child with a time during which he receives unconditional attention, respect and acceptance from an adult important to him and during which he can express his own wishes, needs and feelings through imaginative play and through interaction with the adult. This type of experience over a period of time is expected to allow the child to become more aware of his true feelings—positive and negative—to resolve conflicts about his feelings and learn to express them in appropriate ways, and to develop the kind of positive regard for himself and for others so often lacking in troubled children.

During the first group session with the parents, professional therapist briefly explains the principles of play therapy and encourages the parents to express whatever feelings they have about the therapeutic role they are being taught to take. In the next few sessions, the parents observe the therapist taking the play therapy role with their children, one at a time. After a few weeks, each parent has an opportunity to demonstrate in a play session with his or her own

child what has been learned while the group and the therapist observe the session through a one-way mirror. This enables the group and the therapist to point out errors in the parent's technique.

Once the therapist decides that the parents feel enough confidence in their new role, the parents begin to carry on therapeutic play sessions at home. However, they continue to attend the weekly group meetings where they discuss the home sessions with the therapist and each other and to carry on demonstrations to give the therapist an opportunity for direct supervision.

Selection and training

The Riegel Ridge Headstart Project was fortunate in securing a person on its staff who had already been trained to conduct therapeutic play sessions with her own child. But there is no reason why the same methods used to train persons for filial therapy could not be used in training persons to work with other people's children. Some prejudgment of aptitude, based on evidence of intelligence and warmth, would have to be applied in selecting the trainees, but most important in the final selection of a psychotherapeutic aide would be the observation of the person's ability and skill during the training period.

The therapist would teach the aides such techniques through demonstrating them and then would observe demonstrations by the aides-in-training. Since the essential ingredient of the play therapy is an atmosphere of total acceptance and understanding so that the child will no longer repress his feelings, the supervisor-trainer would have to be constantly on the alert for any evidence of rejection of the child or any of his feelings on the part of the aide. At the same time the aide would have to be taught the importance of properly enforcing the rules of the session. Supervision of the aides after training to detect and correct any errors in techniques that might arise would, of course, have to be continued throughout the duration of the program.

As in filial therapy, the training would involve teaching the aides (1) to try to understand how the child presently feels; (2) to accept the child's feelings no matter what they are; (3) to allow the child always to take the lead in determining how he uses his play time; (4) to enforce the rules of the session with complete firmness while remaining empathic and noncritical; and (5) to demonstrate to the child that his needs are indeed being understood and accepted, by making appropriate but brief statements

such as, "That gets you angry," or "You really like Joan"—in other words, verbally "reflecting" his feelings so that he will grow to recognize and express them.

The first part of the training of nonprofessional persons for such a task might take place in a training group of general child-care aides. Persons showing a special ability to empathize with children, to communicate their understanding to the child, and to be firm or permissive at appropriate times might then be asked to take further training to become psychotherapeutic aides. Such a program would, of course, only be possible if a psychologist, psychiatrist, or psychiatric social worker with special skills in non-directive play therapy were available to the project for training and supervising the aides.

Headstart experiment

The woman employed as a psychotherapeutic aide by the Riegel Ridge Headstart Project had previously been taught the methods of child-centered play therapy in a filial therapy group at the Hunterdon Medical Center in Flemington. A high school graduate in her late twenties, she had achieved a high degree of success in helping her own child. During her employment as a psychotherapeutic aide she has demonstrated that she can also be successful with other people's children.

Soon after the beginning of the 1966-67 term, the project referred six children to its psychological consultant. The reasons for referral ranged from uncontrollable behavior to withdrawn, overly inhibited behavior. The psychologist determined that all six children were in need of psychotherapy because of intense emotional problems and recommended that this be provided under his supervision through the psychotherapeutic aide. The aide began having regular 30-minute therapy sessions with each child twice a week. She would take the child out of the classroom and drive a half mile to the Riegel Ridge Community House, where a room was available for the play therapy session. After the session, she would return the child to the Headstart class and then take the next child to the Community House.

This procedure was followed twice a week for 16 weeks. The aide took notes on every session for use in her conferences with the psychologist. During the first conference, the psychologist outlined the essentials of each child's background and explained the child's needs and the motivations for his behavior. Specific questions discussed in subsequent supervisory

conferences concerned the subtleties in technique, such as how to keep from discouraging the child from expressing negative feelings, and when and how to tell the child that the sessions would end with the school year. The psychologist also encouraged the aide to accept the child's expressions of positive feelings, for example, to allow a child to sit on her lap if the child so desired.

At all times, the supervisor felt confident that the aide was performing her role well and that no child was adversely affected psychologically, even temporarily. This is not surprising, since the aide's role is a nondirective one and does not involve interpretation of the child's behavior to the child.

The case of Carolyn

All six children treated by the aide showed signs of improvement during the period. The case of 4-year-old Carolyn is illustrative.

At the time she was enrolled in the Headstart nursery school, Carolyn and her mother, stepfather, and 7-year-old brother were living with her maternal grandparents. The mother's first marriage had ended in divorce and the mother had only recently remarried. The grandparents had always borne the responsibility of caring for the children, but the grandmother had developed a closer relationship to Carolyn's brother than to Carolyn. On the basis of his observations of Carolyn and information available to him, the psychologist noted that Carolyn was very withdrawn and afraid of strangers, but probably had average intellectual ability.

Usually a fearful, withdrawn child first reacts to play therapy by being very quiet and inhibited. He then gradually becomes more exploratory and begins to play alone with the various toys made available for the session. After a few sessions, he expresses himself more directly in his use of the toys and acts out some of the underlying hostility and repressed feelings which his withdrawal symptom has been covering up. He usually begins to express direct hostility toward the therapist by littering the room, speaking angrily, or breaking a rule. In a successful case, after these middle stages of direct and aggressive acting-out behavior, he shows signs of developing appropriately controlled self-expression. That is, in contrast to both the initial stage of extreme withdrawal and the middle stage of cathartic aggression, he becomes more flexible and expresses his feelings directly but in more socially acceptable and appropriate ways.

Carolyn's behavior in the play sessions with the psychotherapeutic aide followed the expected sequence. During the first play session, she sat the entire time without playing or interacting in any way with the psychotherapeutic aide. Only when the aide told her that there were just 5 minutes left of the session did she make any attempt to play, and that was only by taking a piece of clay and rolling it into a ball. The aide's notebook comment on this session was "Carolyn appeared very unsure of herself, and seemed to be looking for direction and approval."

In her second session, Carolyn behaved in a similar fashion, waiting most of the session before picking up the clay and again simply rolling it into a ball. However, she eventually took up some crayons and scribbled on a piece of paper. The aide noted "Carolyn acted much more friendly today, but at times was still unsure of herself."

In the next two sessions, Carolyn gradually became more at ease, spoke freely, and began to touch and play with some of the other toys in the room. However, she frequently sought the approval of the aide. At the same time, the aide noted that Carolyn was beginning to test whether she would be rejected if she displayed provocative behavior. For example she would drop her crayons and paper on the floor then look at the aide and laugh. Once, she inadvertently broke a crayon and then looked at the aide fearfully and said that the crayon broke by itself. She appeared quite relieved when the aide did not scold her but merely said, "That frightened you."

As the sessions continued, Carolyn gradually gained more confidence and began to vary her activities, using the toys freely and romping about.

She also began to involve the aide in her play. For example, she pretended that the aide was her mother and that they were having a party. Then, after say-

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Riegel Ridge Headstart project. Bernard G. Guerney, Jr., is professor of psychology and the director of the Psychological Clinic at Rutgers. He also serves as a consultant to two public school systems in New Jersey.

ing she was going to clean off the supper table, she swept everything onto the floor and laughed, thus indirectly expressing her hostility toward her mother. After a while she began to express her anger more directly by throwing a bop bag around the room. She continued to express hostility toward the aide. She would tell the aide to draw along with her, but then would take both crayons, leaving the aide with none.

In later therapy sessions, Carolyn continued to express her hostile feelings in such ways. She also began to display some affection for the first time, putting her arms around the bop bag and saying, "Look, I'm hugging it." The aide reported this as a sign of progress, for she had learned that such a spontaneous display of affection usually occurs only when a child has expressed many of the negative feelings that have been blocking the more positive feelings.

Carolyn also became able to work directly on other feelings such as fear. For example, at one session she heard a dog bark and ran to the aide saying that she thought she heard a monster. When the aide said, "You are afraid, aren't you?," Carolyn freely admitted that she was. After repeating expressions of her fears and listening to the aide's "reflections" of them, she walked away and said, "I'm not scared now. I don't think it could be a monster."

The results

At the time of the last few sessions, Carolyn's family was about to move from the grandmother's home, and Carolyn began to talk about how she felt, both good and bad, about this. The aide responded with such empathic statements as "You're happy to be going someplace new but it makes you sad to leave Grandma."

Carolyn also began to express her feelings about herself. Once remarking that her hair was a mess, she picked up a girl doll and threw it down saying it had a "stinky hairdo." But she also learned to be more accepting of herself and her feelings. For example, although she said she disliked the drawings she had made, she asked the aide to put her name on them. Previously she had always torn her drawings up.

Throughout the 16 weeks of sessions, the aide continued having discussions with the psychologist about the meaning of Carolyn's behavior and ways of dealing with it.

By the time the series of sessions ended, Carolyn showed signs of real improvement in the Headstart classroom. When she first came to the Headstart

nursery school, she was a very shy anxious child who lacked the social skills necessary for assimilation into the group and who responded to any adult direction either with a temper tantrum or with sulking. Gradually she became a smiling, chattering youngster who generally responded to adult direction with little objection. Her teacher attributed much of the improvement to her experience of achieving total acceptance from the psychotherapeutic aide.

ONE CANNOT EVALUATE accurately the effectiveness of a program to improve the adjustment of a small number of emotionally disturbed children in such a short period of time without a control group to gauge the contribution which the play therapy provided over and above the contribution of the Headstart classroom experience. However, the fact that all six children showed a degree of improvement similar to Carolyn's gives us reason to believe that the play therapy carried out by the psychotherapeutic aide was effective. We tried to interview the mothers of the six children at the end of the first year of the project to learn their opinions of the experience, but were able to reach only four. Their responses were uniformly positive. For example: "Billy seems to be more relaxed . . . I am very much satisfied with his progress." "Donny has changed a lot. He plays with the kids much better now."

At the end of the Headstart term, the teachers reported that each of the six children was generally more relaxed and more adaptable to the program and to changes in activities.

Obviously, subjective evaluations by persons who are aware of which children received special treatment are far from adequate evidence of a program's effectiveness. At the present time, because of the shortage of funds, plans to launch a program of this type with provision for objective evaluation have been temporarily put aside. However, the psychotherapeutic aide, under a professional therapist's supervision, is continuing to provide play therapy to children with obvious emotional difficulties. We believe that the results are encouraging enough to suggest that other Headstart programs should train, use, and evaluate the effectiveness of adequately supervised nonprofessional people in this sort of role.

¹ Guernsey, B. G., Jr.: Filial therapy: descriptive and rationale. *Journal of Consulting Psychology*, August 1964.

² Guernsey, B. G., Jr.: Guernsey, L. F.; Andronico, M. P.: Filial therapy. *Yale Scientific Magazine*, March 1966.

A PSYCHOTHERAPEUTIC AIDE IN A HEADSTART PROGRAM

II. COMMENTARY

● All of us who have been working with children in Headstart programs have recognized that perhaps 10 to 20 percent of the children enrolled are not able to make full use of the Headstart experience without special help. The kind of help provided by the psychotherapeutic aide described by Andronico and Guerney is an example of one kind of special assistance children may need.

Before proceeding to help such children, however, we need a solid understanding of the sources of the child's difficulties. A wildly disruptive, hyperactive child may have organic problems requiring medical help first of all. Therefore, any hyperactive child, and also any child who does not speak, should be given a thorough examination by a pediatrician who has been fully informed about the child's difficulties in Headstart. In some instances the child may also need a full psychiatric evaluation. Only when it is clear that the child does not need medical help or if he does, that a plan has been made to provide it, should any kind of special psychotherapy be attempted.

Secondly, we need to determine carefully how the child's experience in the group might be modified. In England some excellent therapeutic work has been done within groups, so that the child does not lose time from the group experience. If the activity room is spacious, room dividers can provide a quiet corner where a therapist can work with an individual child in a process similar to that described by Andronico and Guerney, without requiring the child to become oriented to a completely new setting. If a protected corner of the room is not available, another room in

the same setting, such as the teacher's office, might be used for the purpose.

The helping process described by Andronico and Guerney seems to imply that the child is ready and willing to make use of the play materials offered him. Actually, some children are by no means ready for this. One finds children who are extremely hostile to or fearful of other children or adults, who are preoccupied with one activity, or who are terrified of play objects or expressive materials. To such children the therapist may have to take a special approach for a while, such as keeping distant enough that they do not feel threatened, then moving quietly and gradually toward a closer relationship. For some children nonverbal communication lets the child know that the therapist is not going to move any more rapidly than the child wants him to. This may be more important than any words that the therapist can use.

With other children it may be desirable for the therapist to take active steps to help the child feel comfortable. Subtle cues often communicate a child's wish for the adult to remain at a distance or to come closer and play with him. If the child moves toward the therapist, looks at him wistfully, or arouses an empathic intuition that he wants to be cuddled or held, the therapist may find that overtures to the child help to release his spontaneity. Again, the accuracy of the therapist's perception of what the child really wants him to do is more important than words.

The child who seems obsessively preoccupied with one toy may respond gradually if the therapist plays

with a similar toy, gradually expanding the kinds of things he does and then introducing other toys step by step. For example, if a child is afraid to use finger paints, verbal comments on his feelings may not be as effective as allowing him to watch the therapist experiment with the finger paints in the way a child usually does. The child may then infer that it is all right to experiment with the paints himself. Such preparatory stages are needed by some children before they can move into the kind of relationship in which verbal comments on play are helpful.

I would underscore the authors' statement that "the essential ingredient of the play therapy is an atmosphere of total acceptance and understanding" and also their point about the importance of setting and firmly adhering to certain limits in regard to the child's behavior—the child cannot be allowed to hurt himself or the therapist. I would also underscore their emphasis on "trying to understand how the child feels, to accept the child's feelings no matter what they are, and to demonstrate to the child that his needs are indeed being understood and accepted." Some anxious, inhibited children may need the support of gentle initiative from the therapist. Recognizing the child's feelings with such phrases as, "That's scary," "That makes you cross," is a part but not necessarily the major part of play therapy; in some instances the child may do his own kind of "working through" by means of his activity with the toys.

However, a rigid difference should not exist between a therapist's way of helping a child express his feelings and a teacher's way. I have often heard a teacher remark that if she said anything to a child about his feelings she would be overstepping her responsibility, for commenting on feelings "belongs to therapy." This attitude puts a thoroughly unnatural limitation on the teacher's normal communication with children. Teachers of preschool children have to help the children learn about their environment and the names of everything in it, to help them make comparisons—for example, about what is soft and smooth or rough and scratchy—and to learn concepts of space and time. But human feelings are just as much a part of life as things and concepts. A teacher should be able to comment naturally that Johnny made Billy very angry when he knocked down his skyscraper; or that one feels lonesome and worried when one's mother has to go away to the hospital. Talking about feelings should be a natural part of everyday life.

I question the advisability of a parent giving

therapy to his own child. An understanding and accepting attitude toward children's feelings should be a normal parental response, and can be even when parents find it necessary to set limits. For example, a parent might naturally say, "Johnny I know you were mad at Billy when he bumped into your airport, but I can't let you hurt Billy. Tell him to be more careful." In other words, openness and exchange of feelings should be a part of home life. However, for a mother to set a special time to provide her child with "unconditional attention, respect, and acceptance from an adult important to him" seems to me pathetically stilted. I should think it would be confusing to the child to have his mother act one way at one time and another way the rest of the time. At best it is a roundabout way of providing what all parents should provide their children naturally.

Parents, of course, can learn something from watching what therapists do. I would be interested in an experiment in which parents of Headstart children were allowed to observe a therapist with a child through a one-way mirror and then participate in a discussion of what part of the therapist's work could only be done by a therapist and what part could be done by parents.

The supervisor is necessary to any therapeutic un-

By blocking herself off, this preschool child may be trying to assuage anxiety brought on by the presence of other children. Some children need help in adjusting to the group.



dertaking by a nonprofessional person and might be either a psychologist, social worker, child psychiatrist, or pediatrician—any professional person who is thoroughly acquainted with the world and feelings of the preschool child and the implications of therapeutic attempts. Children who are disturbed enough to need special help often exhibit outbursts of anxiety or anger, breakdowns in control, or distortions of thinking, and the therapist with little training and educational background needs help from an experienced supervisor in understanding and dealing with such occurrences. It would be absolutely unsound to let aides who have had only minimal training undertake therapy unless responsible supervision were available at all times.

I feel that it is of the greatest importance to provide Headstart teachers with special help for the children who need more attention than any teacher can provide an individual child, but appropriate supervision must be provided and the helping process adapted to the widely varying needs of individual children.

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The need for more adults trained to assist young children who have been deprived or blocked in their development is a critical one.

However, I seriously question the assumptions of Andronico and Guernsey in relating their experiences in training and using a psychotherapeutic aide in a pre-kindergarten program. Since this plan was derived from a previous therapeutic program in which mothers were trained to treat their own disturbed children, a discussion of it must begin with an examination of what the authors call "filial therapy."

The concept and techniques of filial therapy erase the vital difference between the functions of a mother and of a therapist. The maternal person offers the child affection, protection, guidance and the stimulation, gratification, and limitation suitable to the needs of the developing child and reflecting the mutuality of child and mother. In their confusion between therapy and maternal care, the authors recommend that a mother set aside regular times for appointments with her disturbed or psychologically ailing child, during which she carries out the functions

of a therapist. This is patently a contradiction. If it has appeared helpful to mothers and their children, this may be because the mothers become more comfortable in taking care of their children and not because it is therapy.

In an important sense, the therapist's functions are possible because they are different from those of a mother. The therapist enables the child to express directly and indirectly those feelings, thoughts, and fantasies which in the bosom of the family are usually expressed or maintained in a manner appropriate to the family setting and situation. To encourage a child to feel that the mother at appointed times will observe him and communicate with him differently than at other times is artificial and risky. Even more risky are the distorted assumptions that the theoretical and clinical training of a therapist requires no selection based on qualifications, no systematic education, and no definition of the scope and limitations of therapy.

Perhaps the most astounding implication of the program described is the omission of what can be termed the agreement between the therapist and the child and his parents in arranging the conditions that will make therapy possible. The implicit relationship of mother and child is not the same, nor should it be, as that of the therapist and his child patient. The former encourages an affectionate relationship based on the expectation that the child's developing needs and capacities and the mother's own development are mutually served by this relationship. In the child-therapist relationship, the aim is to help the child express and observe his inner attitudes and feelings so that he can resume a normal development in his family environment, strengthened by his self-understanding. The child who is treated by his parent as a patient may learn to distrust his parent, for he may experience the treatment as an unfair and artificial manipulation by an adult who is more knowledgeable and powerful than himself.

A child's conflicting attitudes toward his parents are unavoidable and necessary as part of growing up. In the process of maturing the child resolves and masters these conflicts, with or without the assistance of treatment. He stands to fail at resolution and mastery if the person toward whom his conflicting attitudes are chiefly directed, his mother, now becomes his therapist, invading the privacy a child usually has in a family and so complicating his conflict.

I also object to the restriction implied in the statement by Andronico and Guernsey that the purpose of Project Headstart is to help disadvantaged children

"achieve intellectual levels nearer to other children." Actually, Headstart is designed to promote social, emotional, and physical as well as intellectual development.

And I would like to ask the authors some questions:

1. What is the "theory that nonprofessional persons may be successfully used as child psychotherapeutic aides in Headstart projects . . .?"

There are theoretical assumptions and formulations that could be invoked to examine this concept of child psychotherapeutic aides, but the authors make no attempt to state the theory or to suggest the limitations of such assumptions.

2. Since when is Rogerian therapy implied by the term child-centered play therapy?

Play therapy was actually introduced by child guidance clinics utilizing psychoanalytic theory, but no one theory of therapy can claim play therapy for its own. Since the project described was initiated with the idea of using persons trained in "filial therapy" as therapists, the errors, distortions, and ambiguities of what is considered "therapy" must have been conveyed to the trainees in this program.

3. What are the rules of the session that should be properly enforced? Why was the "therapy" administered for 30 minutes twice a week?

I believe the authors have confused the term "therapy" with "therapeutic." Many activities, including spontaneous individual play, formal education, and day-to-day experiences in the home, can have a healing or therapeutic influence. However, such divergent activities are not therapy. In fact, from the description in this article of what an aide did in helping one child, it appears that the authors are describing a process of education rather than one of therapy. At least, I hope they are.

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There are many positive roles that may usefully be assigned to nonprofessional persons in work with preschool children. A number of these have been explored during the past 3 years in the New Careers program at Howard University, with generally positive results.^{1, 2, 3}

The authors of the case presentation, Michael P. Andronico and Bernard G. Guerney, Jr., will comment on some of the points made by the three critics in this commentary in the Readers' Exchange section of the next issue of CHILDREN—a section which is also open to comments by readers.

Such roles involve tasks that have customarily been performed by professional persons, for which professional persons are, in fact, "overtrained," tasks that a person of less education can, with appropriate training and supervision, carry out capably without loss of quality in the service. In such a situation the professional person serves as supervisor, trainer, and specialist. He is thus enabled to spend more of his time doing the kind of work for which his professional education prepared him and to amplify the impact of his professional education and experience.

I have been impressed with the "linkage" function that the neighborhood nonprofessional person can bring to the service situation, particularly in the disadvantaged community. The nonprofessional person is frequently much more familiar with the life styles in the local community, speaks the same language as the person being served, and represents for him a figure with whom it is much easier to identify.

However, for the benefit both of the program and the nonprofessional aide, any program using nonprofessional workers should provide them with the support of a continuous, structured training program, including on-the-job supervision, related educational experiences, and opportunities for advancement to higher levels of function and responsibility as experience is gained and skill developed. In the New Careers program at Howard, we have found that without these three elements, the early positive effects of enthusiasm, pride in involvement, and sense of novelty soon wear off, results become less clearly apparent, and the trainee-aide loses his motivation for the work and frequently drops out. It is never enough simply to define a new role, train a person once-and-for-all to perform it, pay him for his work, and leave it at that.

If the use of nonprofessional persons is to be fully effective, the definition of function and role for any type of nonprofessional helper must only be the first

step in a sequence of steps for developing or reorganizing a service program. If several different functions are defined for nonprofessional persons working at different levels and the roles of the professional persons are redefined and adjusted so that they can use their special skills more effectively, the result will be improved effectiveness of service.⁴

In general, the use of a nonprofessional person to provide ancillary services to a member of a children's group who has special needs, as in the case described by Andronico and Guernsey, represents the kind of nonprofessional function that has been found to be very effective. However, the reader who is concerned with the applicability of this experiment to his own program should try to distinguish between the usefulness of the described nonprofessional "helping role" for children with special problems and needs and the theory and terminology of the specialized technique called "filial therapy" or "child-centered Rogerian play therapy."

As a psychiatrist, I have found that the child-centered Rogerian therapy is not applicable to all pre-school children with emotional problems and disturbances and, in fact, may be quite the wrong approach to helping disturbed, disadvantaged pre-school children from urban ghettos, whose major problems usually do not stem from repression but rather from adult abandonment, lack of concern, and lack of warm but firm direction. The case described by Andronico and Guernsey should be used to stimulate thinking and experimentation with roles for aides in a Headstart-related therapeutic program rather than to provide a model of a technique to be followed. The very fact that an adult gives a disturbed child special attention and warmth may have much more to do with the outcome than the "non-

directive" aspects of the "technique." This is an area requiring extensive, controlled study and followup as do many other currently accepted techniques of "psychotherapy" with children.

It is particularly important to consider whether the kind of activity described by Andronico and Guernsey, although labeled and set apart as "therapy," might be much more effective if incorporated into the basic Headstart group program itself. There are various levels at which an aide could serve both preventive and corrective goals in working with children as part of the total program and contribute much to the basic conception of the educational process itself without being trapped into the psychotherapy paradigm.

I hope that the authors will continue their experimentation, perhaps in a direction more closely a part of the Headstart curriculum itself; and that for future reports they will prepare data both on followup of the children in their experiments and on comparison with control groups.

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The child . . . reacts to what he feels to exist in the outer world rather than to actual reality. His consequent unwillingness to accept restrictions, to renounce or to postpone wish fulfillment, his over- or underestimation of his own powers (feelings of grandeur, sense of inferiority)—all these constitute the young child's inherent social maladjustment which gives way gradually, as the sense of reality develops to a growing social adjustment.

Anna Freud, "The Writings of Anna Freud; Volume IV, 1945-1956" International Universities Press, New York, 1968.

NEW HOPE FOR BABIES

of Rh NEGATIVE MOTHERS

JANE S. LIN-FU

Each year in the United States an estimated 200,000 to 300,000 pregnant women face the hazard of becoming sensitized to the Rh blood factor. While not all of these women become sensitized by such pregnancies, for the thousands who are so sensitized, the consequence is serious and often tragic. Once a woman becomes sensitized to the Rh factor, her future pregnancies are likely to result in infants with hemolytic disease, some of whom may be stillborn and some of whom may die shortly after birth or live with neurological defects. Hemolytic disease of the fetus and newborn has been occurring in one in every 150 to 200 pregnancies in the United States.

Recently, however, the development of the Rh immunoglobulin for the prevention of sensitization to the Rh factor has opened up an entirely new horizon for Rh negative women. To the couple involved, it means that they no longer need to face each pregnancy with fear and suspense or to prevent pregnancy because of the high risk of a tragic outcome. To the medical profession, it means a major medical advance, a leap from emphasis on treatment to emphasis on prevention.

For many years, hemolytic disease was a cause of repeated tragedy in affected families and an enigma to physicians. The etiology of the disease was unknown, the perinatal mortality associated with it was formidable, and among the surviving infants, neurological sequelae, including mental retardation, hearing loss, and cerebral palsy, were common.

After discovery of the Rh factor in 1940 and its role in the pathogenesis of the disease, treatment of affected infants became possible through exchange transfusion—that is, an almost complete change of the baby's blood shortly after birth. In the past few years, a procedure for intrauterine transfusion has been developed that can save some severely affected fetuses that would otherwise be stillborn. While these therapeutic measures have immensely improved the rate of survival of affected infants, Rh negative women have, until recently, still had to face each pregnancy with anxiety and uncertainty. Neonatal deaths have continued to occur in the severely affected infants, and a significant stillbirth rate has remained. Furthermore, the lifesaving measures themselves involve some risks.

The availability of Rh immunoglobulin promises a radical change. Hemolytic disease may in a generation's time become so rare as to be only of historical interest.

Rh factor

The Rh factor is a genetically determined substance present in the red blood cells of most people. Its name is derived from rhesus monkeys, which were used in the study that led to its discovery. Persons whose red blood cells possess this factor are referred to as Rh positive, and persons without it, as Rh negative. When introduced into the bloodstream of people who do not possess it, the Rh factor acts as an antigen

stimulating the person's immune system to produce anti-Rh antibodies. These anti-Rh antibodies have a special affinity for Rh positive cells, which they cause to be hemolyzed, or destroyed.

Marriage between an Rh negative woman and an Rh positive man is often described as Rh incompatible, as is pregnancy of an Rh negative woman with an Rh positive fetus. In an Rh incompatible mating, if the husband is homozygous for the Rh factor, that is, if he carries two Rh positive genes, all the offspring will be Rh positive, but if the husband is heterozygous, or carries only one Rh positive gene, the chances are that 50 percent of the offspring will be Rh positive and 50 percent Rh negative. An Rh negative woman married to an Rh positive man can therefore have either Rh positive or Rh negative children, depending on the zygosity of the husband. Only when she becomes pregnant with an Rh positive fetus is she faced with the potential danger of Rh sensitization. However, not all Rh negative women with Rh incompatible pregnancies become sensitized.

Among Caucasians, about 15 percent of the population is Rh negative; among Negroes, 5 to 7 percent; and among American Indians, Chinese, and Japanese, less than 1 percent. From these figures, it has been estimated that Rh incompatibility occurs in about 13 percent of marriages between Caucasians and about 5 percent of those between Negroes.

Hemolytic disease

During normal pregnancies, and particularly during labor and delivery, fetal red blood cells often find their way into the mother's blood circulation—a process known as fetal transplacental bleeding. In an Rh incompatible pregnancy, Rh positive fetal red blood cells that enter the mother's bloodstream may stimulate the mother's immune system to produce anti-Rh antibodies. These antibodies in turn cross the placenta and enter the fetus, destroying the fetal red blood cells. The result is hemolytic disease of the fetus and newborn.

Many blood factors can cause hemolytic disease but the Rh factor is most important, because of its frequency and the severity of the disease when it has been involved. Incompatibility in the ABO blood system (as when the mother's blood is type O and the fetus' blood is type A or B) also causes hemolytic disease in many infants, but most of these cases are mild and require no treatment. Very occasionally, rare blood factors are responsible for cases of hemolytic disease.

In hemolytic disease, destruction of the red blood cells generally begins in the fetus and continues in the newborn. The two salient clinical features, jaundice and anemia, are both the direct results of such hemolysis. Jaundice, a yellowish discoloration of the skin and whites of the eyes, occurs as blood cells are destroyed, releasing an excessive amount of bile pigments into the blood. Anemia is the result of red blood cell destruction.

Clinical manifestations of hemolytic disease vary. A fetus may be so severely affected that it dies in utero and is stillborn. Or the infant may be born prematurely with massive edema, or accumulation of fluids in his tissues, a condition called hydrops fetalis, and die shortly after birth of heart failure. Or the infant may become intensely jaundiced within minutes or hours after birth, a condition known as icterus gravis neonatorum. In less severely affected infants, congenital anemia may dominate the clinical picture. Enlargement of the liver and spleen is common among infants with hemolytic disease and represents an effort of the body to compensate for the excessive blood destruction by increasing the site of blood formation.

Until treatment became available, neonatal mortality was 50 percent among infants born alive with hemolytic disease. Between 5 and 15 percent developed kernicterus, a form of brain damage caused by an excessive amount of bile pigment in the blood. About 70 percent of the infants with kernicterus die within 7 days of birth. Among those who survive many have neurological handicaps. At one time kernicterus was responsible for 10 percent of all cases of cerebral palsy.

Early research

The forms of hemolytic disease of the fetus and newborn were first described in medical literature as separate entities. In 1932, Diamond and associates observed that hydrops fetalis, icterus gravis neonatorum, and congenital anemia were different manifestations of the same fundamental disease process. Diamond and his research team coined the name erythroblastosis fetalis, based on the increased number of the immature red blood cells, or erythroblasts found in blood and tissues of affected fetuses and infants. Recently, increasing numbers of physicians have been using the name hemolytic disease, because hemolysis is more typical of the disease than is erythroblastosis.

The Rh factor was discovered by Landsteiner and

Wiener in routine studies on antibodies in 1940.² They found that red blood cells of the rhesus monkey, when injected into rabbits, stimulated the production of an antibody that acted on the monkey's blood and caused it to clump or agglutinate. In laboratory tests the antibody affected red blood cells of most human beings in the same way. Red blood cells that could be agglutinated by serum containing the antibody were found to possess the antigen present in rhesus monkeys and were labeled Rh positive, while red blood cells that could not be agglutinated were termed Rh negative.

A year after the Rh factor was discovered, Levine and associates³ suggested that erythroblastosis fetalis may be the result of hemolysis or destruction of the fetal red blood cells caused by maternal anti-Rh antibodies and provided statistical proof of this hypothesis. Shortly thereafter, it became clear that sensitization of an Rh negative woman may be caused not only by an Rh incompatible pregnancy but also by transfusion or intramuscular injection of Rh positive blood.

The discovery of the pathogenesis of hemolytic disease made it possible to develop methods of treatment and prevention. Typing of the blood for the Rh factor in both donor and recipient before blood transfusions represented the first systematic effort to prevent Rh sensitization of an Rh negative recipient. This procedure, adopted generally in 1947-48, has since become a routine procedure in most blood transfusion laboratories and has practically eliminated sensitization due to blood transfusions. Because the problem of Rh sensitization caused by an incompatible pregnancy seemed to defy solution, attention was concentrated on treatment of the affected infant.

In 1947, Diamond⁴ and associates, introduced exchange transfusion to treat infants with hemolytic disease. This lifesaving technique removes the infant's own blood and replaces it with Rh negative blood, which is not vulnerable to destruction by maternal antibodies. Exchange transfusion has greatly reduced the number of deaths from hemolytic disease in newborn infants and has prevented kernicterus

in most survivors. It is usually supplemented by induced early termination of pregnancy in Rh negative women to prevent stillbirth and limit the severity of the disease. Exchange transfusion is not without limitations, however; it rarely saves hydropic infants and it has no effect on stillbirths. Nevertheless, it was the only form of therapy that offered any hope for victims of hemolytic disease for many years. This technique and early termination of pregnancy together have reduced neonatal mortality among such infants from 50 percent to less than 5 percent.

In 1963, Liley⁵ introduced the bold technique of fetal or intrauterine transfusion to save severely affected fetuses. This procedure, which requires a highly specialized medical team, is not yet widely available, however, and it is useful only in carefully selected cases. Even in skilled hands, intrauterine transfusion is associated with mortality of 5 percent for the fetus and very real risks for the pregnant woman. The overall incidence of stillbirth in hemolytic disease is generally considered to be between 15 and 20 percent; intrauterine transfusion could salvage between 30 and 50 percent of these infants.

Immunoglobulin

All these procedures are useful only after the fetus or infant has become affected by hemolytic disease. But the ultimate goal in the control of any disease is prevention. For hemolytic disease this goal is now within reach. The development of Rh immunoglobulin, a gamma globulin preparation with a high concentration of anti-Rh antibodies, makes it possible to prevent an Rh negative woman from becoming sensitized to the Rh factor during pregnancy and childbirth.

Many investigators contributed to the development of Rh immunoglobulin. Wiener⁶ in 1948 suggested the theory of fetal transplacental bleeding to account for the sensitization of the pregnant woman. But it was not until 1957 that Kleihauer and associates⁷ devised a rapid and accurate method to detect small amounts of fetal red blood cells in the maternal blood. The test is sensitive enough to detect as little as 0.1 milliliter of fetal blood in 5,000 milliliters of maternal blood.

Studies using the Kleihauer test have demonstrated that a few fetal red blood cells may be found in the pregnant woman's circulatory system as early as the first trimester of pregnancy, but that larger numbers are found in late pregnancy, during labor, and at delivery. Such studies have also demonstrated that

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the risk of maternal Rh sensitization is correlated with the amount of the fetal bleeding into the mother's circulatory system. In other words, the chance of a woman becoming sensitized to the Rh factor increases as the fetal cell count of the pregnant woman increases. This observation explains why Rh sensitization occurs more frequently following traumatic or manipulative procedures resulting in massive fetal hemorrhage during labor and delivery.

On the basis of these findings, research workers reasoned that Rh sensitization of an Rh negative woman can be prevented by eliminating the fetal red blood cells from her body before they have a chance to stimulate production of anti-Rh antibodies. But the questions remained: When should this be done? And how? Sensitization only very rarely occurs during the first Rh positive pregnancy, despite the fact that fetal transplacental bleeding during pregnancy allows ample time for antibodies to be formed. Antibodies are seldom demonstrable in a woman's blood within a 2-month period following the delivery of her first Rh positive infant. This long period of latency between the introduction of fetal red blood cells into the maternal circulation and the appearance of antibodies led to speculation that the raised levels of certain hormones during pregnancy may render a woman relatively unresponsive to sensitization and that fetal red blood cells in the mother's circulation become an effective antigen only after delivery when the mother's immune system is no longer under suppression. If such were the case, research workers reasoned, measures to eliminate the fetal red blood cells from the maternal circulation could be delayed until after delivery.

Two studies

In 1960, two independent groups of investigators began to study the possibility of preventing Rh sensitization. In New York City, Freda, Gorman, and Pollack⁸ based their work on the immunological principle that passive immunity can block active immunity. When this principle is applied to the Rh phenomenon, it means that anti-Rh antibodies injected into an Rh negative woman should prevent her body from making anti-Rh antibodies when she is challenged with Rh positive red blood cells from her fetus. The investigators gave intramuscular injections of Rh immunoglobulin to a group of Rh negative male volunteers. The immunoglobulin prevented formation of anti-Rh antibodies in these men when they were later injected with Rh positive blood. In

a control group of Rh negative men who did not receive Rh immunoglobulin but were injected with Rh positive blood, several developed anti-Rh antibodies.

At the same time, Finn, Clarke, and associates,⁹ in Liverpool, England, started out from a different premise. It is well known that ABO-incompatible pregnancy often protects Rh negative pregnant women from Rh sensitization. The English workers reasoned that, if the woman's anti-A and anti-B antibodies destroy the fetal red blood cells before they stimulate the production of anti-Rh antibodies, the protective action of the anti-A and anti-B antibodies in the pregnant woman's blood can be mimicked by anti-Rh antibodies. In a carefully controlled study, a group of Rh negative men were given intravenous injections of plasma containing a high concentration of anti-Rh antibodies and Rh positive red blood cells. These men did not develop anti-Rh antibodies, but the men in a control group did.

Since these experiments were carried out, clinical trials of Rh immunoglobulin have been conducted among Rh negative women in 43 medical centers in various parts of the world.¹⁰ To date, more than 3,000 pregnant Rh negative women have participated in the clinical studies. Results of two separate studies involving a total of 1,807 women are now available. None of the women showed anti-Rh antibodies in their blood prior to and at the time of delivery. The infants being born were all Rh positive, ABO compatible with the mother, and in laboratory tests showed no maternal anti-Rh antibodies attached to their red blood cells. The women in each study were divided into an experimental group and a control group. All women in the experimental group were given one intramuscular injection of Rh immunoglobulin within 72 hours after delivery.

The two studies differed only in dosage. In the first study, 300 women were given an injection of 5 milliliters of immunoglobulin; 227 women served as controls. None of the treated group became sensitized in the 6 months after delivery, but 19 of the women in the control group did. In the second study, 781 women were given 1 milliliter of Rh immunoglobulin after delivery; 499 women served as controls. When studied 6 months later, one woman in the treated group and 32 women in the control group had become sensitized.

Because pregnant women sometimes become sensitized to the Rh factor without developing demonstrable antibodies, a subsequent birth of an unaffected Rh positive infant will serve as ultimate proof that

the women in the treated groups did not become sensitized. Followup reports have been made on 145 women from the two studies who have had a subsequent Rh positive pregnancy. Among 82 treated women, 81 delivered unaffected infants. Seven of the 63 women in the control group delivered infants affected with hemolytic disease.

The results clearly indicate that a single intramuscular injection of at least 1 milliliter of Rh immunoglobulin given within 72 hours after delivery of an Rh positive infant will effectively prevent Rh sensitization of the Rh negative woman under normal circumstances.

Implications

Clinical trials of Rh immunoglobulin have indicated that side effects are infrequent and—when they do occur—usually mild. Since Rh immunoglobulin provides definite protection against Rh sensitization and since at present the state of sensitization is irreversible, all women who face the potential danger of Rh sensitization should be offered this effective measure. For all unsensitized Rh negative women who give birth to Rh positive infants, the injection should be repeated after every Rh positive pregnancy within 72 hours of delivery.

Admittedly, the adoption of such a routine procedure would mean that many women would be given Rh immunoglobulin unnecessarily. However, there is no way today of predicting which Rh negative women will become sensitized after delivery of an Rh positive child. One can only speculate in terms of high or low risk. It, therefore, seems advisable that Rh immunoglobulin be given to everyone who is confronted with the potential hazard of becoming sensitized to the Rh blood factor.

The use of Rh immunoglobulin is a preventive measure. It is not indicated for women who are already sensitized to the Rh factor. Moreover, Rh immunoglobulin is not indicated for Rh negative women who have an Rh compatible pregnancy, for they do not face the risk of Rh sensitization. More important, Rh immunoglobulin should not be given to anyone

during pregnancy because it can cross the placenta and damage the fetus.

THE PREVENTION of Rh sensitization by using Rh immunoglobulin represents a new approach to an age-old problem. Now a woman no longer need wait for sensitization to occur, for hemolytic and other pathological processes to be initiated, or for the fetus or infant to be damaged before taking steps to protect her infant. A simple procedure can avert a disastrous chain of events. If this procedure is systematically applied to all mothers who are faced with the possibility of Rh sensitization, the incidence of hemolytic disease of the fetus and newborn can be reduced nearly to a vanishing point, once the present generation of sensitized women has passed the child-bearing age.

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A SOCIAL WORK MISSION TO HIPPIELAND



DAVID CRYSTAL
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 In the summer of 1967, the Jewish community of San Francisco offered the service of a social work "participant-observer" to the young people who were pouring into the Haight-Ashbury section of the city, attracted by its fame as the Mecca of the Hippies. This service has since been terminated because of the changed character of the area. However, it taught the sponsoring organizations a great deal about the value and limitations of an individualized service in helping young people whose alienation from society derives in large part from the character of society itself.

The Haight-Ashbury section of the city where most of the Hippies were concentrated is a neighborhood of some 45 square blocks with a normal population of 8,000 to 9,000 people. Before 1964, when many young newcomers began arriving, it could be characterized

as a relatively stable neighborhood inhabited by families of low-middle income.

Beginning in 1964, former "beatniks," graduates from the Berkeley "freedom movement," former civil rights workers, *avant garde* intellectuals, and other young people who were disengaging themselves from a more active role in society began to move into the area. By the winter and early spring of 1967, some 5,000 Hippies had swelled its population. Other Hippies were living in contiguous neighborhoods.

The Hippie movement was, and still is, characterized by the use of drugs (especially LSD and marijuana), the espousal of free sex and elimination of the "double" standard, and personal philosophies based on love and sharing with the "tribe." Groups of young people shared living quarters and food perhaps as a manifestation of their philosophy, perhaps, too, as a result of the limited living space available and the general meagerness of their incomes. Intellectualism declined in prestige as "action," "sensing," "meditation," and "Eastern mystic experience" climbed in the hierarchy of values.

Even at the height of the Hippie invasion the majority of the inhabitants of the Haight-Ashbury district still consisted of the oldtime residents, members of the "straight" community who customarily had had an accepting attitude toward newcomers but who tended to become antagonistic to the young immigrants as the crowding increased, rents went up and the unconventional behavior became more visible. Most of the newcomers were unemployed or employed only part time. Some were artists, writers, merchants of hip ornaments or peddlers of hip publications. Others panhandled and many sold drugs. The newcomers also included a few aggressive young people of the "Hell's Angels" type who apparently came to exploit or intimidate the Hippies, but found themselves accepted. The few isolated incidents of violence that occurred were probably inevitable in this strange *mélange* of cultures.

Concern and action

In the spring of 1967, the Hippies already living in the area were heralding the coming "summer of love," and the city newspapers and television stations were predicting the in-migration of as many as 200,000 young people from all parts of the United States and Europe. The social agencies of San Francisco were acutely aware of the threat implicit in such sudden mass in-migration. A committee was formed representative not only of voluntary and pub-

Based on a paper presented at the 1968 forum of the National Conference on Social Welfare.

ie social and health agencies but also of Hippie organizations. From the committee's meetings emerged a plan to locate and house runaways under 16 years of age. As a result, a local church provided and staffed a residence, called Huckleberry House, to shelter and serve young runaways attracted to San Francisco by the movement. The cooperation of the police department made possible a form of service that, at least for a while, could bypass arrest in working toward the return of the young people to their homes.

Other organizations also offered services to the Hippies, especially casework agencies, colleges, and churches; but generally these services were provided only on an occasional or emergency basis.

The Hippies themselves also established services. These included the Switchboard, which offered Hippies a 24-hour referral and information service and an employment service, both organized and operated by a community-conscious group called the "Diggers."

The organized Jewish clergy of the Bay Area expressed concern about the proportion of Jewish young people among the Hippies of Haight-Ashbury, rumored to be as high as 40 percent. A special Passover Seder held in the area attracted 80 young men and women. Some people suggested that this response reflected "an underlying yearning among the young Hippies for renewal of communication between family and community." Others suggested that the young people were simply hungry.

There were reports of rampant illness, malnutrition, and unsanitary living conditions among the Hippies, including the Jewish youngsters. In addition, Jewish agencies and temples were being besieged by inquiries of anguished parents from all over the country whose children had left home, drawn magnetically to the new frontier. Because of the general concern and the need to find out more about the situation, the Jewish Welfare Federation decided to sponsor a special Haight-Ashbury project under the joint auspices of the United Jewish Community Centers and the Jewish Family Service Agency. The project had the following tentative objectives:

1. To assess the extent of Jewish participation in the Haight-Ashbury Hippie movement.
2. To cooperate with the service programs in the area that were attempting to meet the urgent needs of individual young people for medical, psychological, and economic assistance.
3. To report needs pertinent to immediate and

long-term planning to an advisory citizens committee set up by the Jewish Welfare Federation.

4. To receive and refine impressions of the factors that disposed young people to become Hippies.

5. To encourage young people to return to the accepted styles of community life.

Impressions and misgivings

In committing itself to this project, the planning body expressed some misgivings, based largely on the following impressions of the Hippie movement:

1. The Hippies' characteristic detachment from struggle and from involvement with the "straight" world, their emphasis on easy, accepting relationships with one another, and the absence among them of overt, aggressive behavior might conceal a deep, covert hostility to society, which would render them inaccessible to any kind of relationship with any agency of the so-called "establishment."

2. Because the theme of the Hippie movement was "tune in, turn on, and drop out," the movement seemed to magnetize toward it diverse kinds of young people with one common attribute—a passive rejection of all the mores and values of our culture. Those who were attracted to the movement seemed to be signifying a rejection of all active social protest and to be saying in effect "what's the use?" (Protest against the war in Vietnam provided the one exception to this refusal to confront society.)

3. The unconventional dress and behavior characteristic of the Hippies suggested a deep nostalgia for earlier times, presumed to be simpler, more idyllic, and more conducive to clearly defined social and personal relationships. The long hair and beads, the dress styles borrowed from the past, such as the tunic and sandals of early Christian-Roman times, suggested, as one anthropologist put it, "the search for a lost childhood." Other evidence that regressive withdrawal tendencies were pervasive among these young people could be found in their predilection for discussing mystical philosophy and their search for "mind-expanding experiences" either vicariously through the arts or directly through the use of drugs.

4. Individual Hippies as well as their organized groups asked for nothing, but accepted whatever was made available to them. In other words, there seemed to be a pronounced social trait among these young

people of deep, passive dependency. The social work members of the project committee had often dealt with this trait in individual clients and knew its clinical manifestations and causes. But what did it mean as a generalized social trait?

5. The Hippie speech patterns and new vocabulary as well as the style of their arts and crafts revealed a consistent use of vague, abstract, symbolic forms as substitutes for clear, precise definition in communication. Here again seemed to be evidence of a tendency to turn away and look inward and backward. Was this tendency among the Hippies an early symptom of a regressive reaction to cumulative stress on the part of society itself? If so, did the movement tend to attract the more maladjusted members of our young population? Where did social movement and personal pathology diverge?

The beginning

In spite of these impressions, the committee went ahead with its plans to employ a social worker to explore Hippie land as a participant-observer. It chose a young woman who identified positively with the Hippie movement, but who was "still committed to the value-system of the mainstream of American life." Youthful, sensitive, intelligent, empathic, she had already worked in the Haight-Ashbury community as a volunteer. To indicate her role as a liaison person from the "establishment" the committee provided her with an office in the community.

One of the first things the social worker did was to send a letter to all Jewish family service agencies in the United States and Canada and to all synagogues and temples in the United States informing them of the establishment of her office and inviting inquiries about individual young people. She also quickly made herself known to the Hippie organizations in the Haight-Ashbury district as well as to the organized committee of social agencies serving the area. She put up a sign on the office door, "The Jewish Welfare Federation loves you." (Later she changed this to "Bet Shalvah"—House of Peace and Tranquility—in accordance with the tendency in the district to create a mystical, romantic aura around all organization forms.)

And then things began to happen!

Irate contributors to Jewish philanthropy began telephoning the offices of the Jewish Family Service Agency and the United Jewish Community Centers to complain that heavily bearded, strangely garbed men and barefooted, oddly made-up girls had been

seen going in and out of an office on which the name Jewish Welfare was clearly marked, and from which emanated the sounds of guitar music, a folk-rock band, and other unwelcome noises. At the same time the social worker in the new Haight-Ashbury office was receiving long distance calls—some of them from as far away as Montreal and Tallahassee—with anxious requests for her to search for a son or daughter who had presumably headed for San Francisco, to call back as soon as the young person was found, and to see that food and shelter were provided.

Meanwhile the city was becoming alarmed about the prevalence of illness among the Hippies—especially hepatitis, venereal disease, and respiratory infections. The crowded Hippie "pads" threatened to become contagion centers unless the community agencies and the city provided special help. The newspapers dramatized the danger, and the whole community seemed to polarize into those citizens who felt emergency relief measures should be immediately established and those who would deny any help hoping thereby to stop the tide of in-migration and, in fact, to force the outsiders to move away.

Thus in the early weeks of the project, the social worker became absorbed in working with representatives of other agencies to find ways of meeting the health crisis. Consideration was given to establishing a small convalescent center, but this failed to materialize. The worker then supported efforts to achieve extension of existing medical facilities and establishment of a clinic within the Haight-Ashbury district.

So much concern was aroused in the community by these efforts and by the alarm expressed by the San Francisco Department of Health that a number of physicians, psychiatrists, social workers, and nurses formed their own Haight-Ashbury medical clinic, contributing their professional services on a volunteer basis. In addition, a hospital affiliated with the Jewish Welfare Federation, after some persuasion from the project social worker, extended its clinic facilities to the young people suffering from infectious diseases and established special procedures for expediting their treatment. These services did not prove adequate for meeting all the health needs in the Haight-Ashbury district, but their existence did arrest a serious health problem.

Throughout the health crisis, the young residents of the Haight-Ashbury area did not themselves demand additional health services. However, some of the Hippies, especially the Diggers, quietly provided the sick with concrete help in the form of food, clothing, and money, which they received from con-

cerned people in the community at large, although they did not conduct any formal solicitation for contributions.

Service to individuals

The Jewish Welfare Federation had hoped that its project in Haight-Ashbury could steer those youngsters whose emotional problems had driven them to join the Hippie movement to the agencies that could help them confront and deal with their problems. However, the project's social worker made very few referrals to such agencies. This was not because of any lack in her ability to establish contact with young people in trouble. On the contrary, she became adept at communicating with the young societal dropouts and seemed to be well accepted in Hippieland as a participant-observer. She did locate some runaways and expedited their return home. But, in general, she could not serve as a bridge back to the "straight" community.

By and large, the young people in need could willingly take the concrete services brought to them—meals, clothing, money, medication. They received any form of relief from immediate pressure with appropriate feeling, but always in terms of the present without reference to past or future. Their dialogue, analysis, and planning stemmed from the current "scene," and the current scene did not allow for consideration of the future. They were not interested in resolving a problem by changing their present pattern of adjustment.

In her person-to-person interviews, the social worker rarely found it possible to use an immediate need as a basis for the kind of deeper individual probing that would result in a referral to a counseling and psychiatric agency. Even when she did manage to make a referral, the resultant service usually only covered the crisis such as the immediate consequences of a "bad trip" (a toxic reaction to drugs) or another health emergency. Once a crisis was relieved, the agency dealing with it had great difficulty in engaging the young person in a consideration of its causes.

In a few cases, however, a deeper involvement of the young client was achieved. These cases nearly all involved young people who could not find emotional support in their affiliation to the Hippie movement. For them their Hippie experience was but another phase in a long history of personal maladjustment and had not brought them the gratification they had sought. In a sense, they were deviates from the deviant culture itself and, hence, were more amenable

to continuing contact. As such they gave little promise of achieving full rehabilitation. Some of these young people continued in casework treatment on a supportive basis for a long time and moved gradually away from the Hippie anchorage. However, they did not really become integrated into the "straight" world but remained on the periphery.

The social worker referred several youthful runaways under 16 to Huckleberry House for immediate haven and a marshalling of the necessary counseling services. She found that in some of these youngsters the magnet of Hippieland had reinforced an already existing adolescent conflict and the runaway experience had opened up a rich opportunity for exposing the past resistance to seeking help in resolving a long-standing family problem.

The social worker also dealt with a number of young women who had been trapped into unwanted pregnancies by their yearning for acceptance and love. Usually they were very willing to accept the community services established for unmarried mothers. In many of these cases the pregnancy brought to the surface the emotional conflicts for which the Hippie movement had served as a foil.

The social worker also met a number of deeply disturbed young people for whom the camaraderie and outer symbols and rituals of the Hippie movement seemed a materialization of their fantasy life. These young people were usually excessively dependent persons, whose need to cling to and exploit others and lack of any sense of reciprocal obligation seemed to represent a displacement to friends and "pads" of emotional grievances against family and home. The project worker referred a number of such young people to the family service agencies, but the agencies had only limited success in helping them arrest their repetitive pattern of flight, clinging, and rejection. In basic psychosocial disturbance, these young people resembled many of the people ordinarily seen by family service agencies except that their invariable use of drugs complicated the treatment process.

Some observations

For the most part, the social worker concerned herself with observing the character of the Hippie group and the kind of values and cultural change it represented. She found that the Hippies did not use social agency help to an appreciable degree and that, with a few exceptions, they did not disrupt or interfere with community life. She confirmed reports that a large proportion of the Hippies consisted of Jewish

David Crystal, left, has been director of the Jewish Family Service Agency in San Francisco for 10 years. He received his doctorate in social welfare from Columbia University in 1957. Irwin H. Gold, executive director of



the United Jewish Community Centers in San Francisco, received his master's degree in social work from the University of Pittsburgh.

young people from middle-class backgrounds. This fact could perhaps be expected in a movement of middle-class youth in revolt against middle class standards, for the Jewish community in America is predominantly middle class, and Jewish young people have always participated in the major drives for social change.

The social worker also found that most of the Hippies in the Haight-Ashbury section were between the ages of 14 and 24, the majority being between 17 and 22. These ages encompass the period of life that has been called "the age of emancipation"—a stage when young people are apt to rebel against all forms of parental and societal authority in their attempt to achieve what Erikson has called a "sense of identity,"¹ that is, a sense of integrity and of firmness of self and outlook.

Thus, for many young people the Hippie movement may serve as a special ground for the expression of normal growth. It features the distortions of our adult value system. Indeed the Hippie orientation mirrors in reverse those features of society that handicap the achievement of identity and integrity. Instead of conforming with clocklike efficiency and conformity, the Hippie tends to be extremely casual, individualistic, and nonconformist; instead of emphasizing duty and obligation, he emphasizes "freedom" to respond to impulse and desire; instead of using aggression and power to get his way (individually or politically), he uses love and consent and takes a laissez-faire policy with respect to others.

No one really knows how many Hippies came to San Francisco in the summer of 1967. Estimates range from 10,000 to 100,000. Most of the newcomers, however, stayed only for a short time, some only for a week or two, and as the summer progressed, it became apparent that more young people were leaving the area than were coming in. There were probably not more than 7,000 Hippies living in the Haight-

Ashbury section at any one time, not counting the several hundred who were coming and going each day. By August this figure was probably cut in half; by October it was probably no more than 1,200.

In the summer of 1968, there was a sudden resurgence of a Hippie-like migration into the Haight-Ashbury area, but this was short lived. Today a hard-core group of Hippies remains, but on the whole the Hippie movement seems to have lost its uniqueness and cohesion as young people have diverted their energies to other methods of protest.

Most of the facilities set up for or by the Hippies in the Haight-Ashbury section in 1967 are now closed, including Huckleberry House and the special medical clinic. The Jewish Welfare Federation withdrew its social worker from the area in December 1967, leaving to the Jewish Family Service Agency the responsibility for providing emergency casework service to young people in the area and for dealing with inquiries about runaways, which had dried up to a trickle. The social worker's observations, however, convinced the sponsoring agencies that the problems of today's alienated youth are larger than the individual and stem from the failure of the institutions of society. A committee of the Jewish Welfare Federation, therefore, has since been addressing itself to ways the existing Jewish institutions might be modified to serve young people more effectively.

We believe that the Hippie movement was not entirely a transient, meaningless fad. Its widespread appearance conveyed a message that could not be hidden by adult response with guilt-provoked righteous indignation: young people have seen through the hypocrisy of a society where vaunted idealism glorifies the spirit of the individual and rampant materialism degrades it.

Every generation has its Bohemian element with distinctive characteristics reflecting the particular imbalances of the times and carrying a symbolic message to the whole society. Today's young Bohemians, the Hippies, represent a protest against depersonalization, computerized thinking and doing, and above all, the distortion between people's daily living and their alleged ethics and values.

As a deviation from social norms, the Hippie movement appears to be regressive, infantile, and sick. But is the norm normal? Or is today's idea of a "successful adult" itself a distortion of a truly human, integrated personality?

¹ Erikson, E. H.: *Identity: youth and crisis*. W. W. Norton & Co., New York, 1968.

DEVELOPING MANPOWER FOR THE WORLD'S SOCIAL WELFARE NEEDS

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How to get and train the manpower for carrying out the social welfare programs necessary for national development occupied a major portion of attention at the first Conference of Ministers of Social Welfare, convened by Secretary General U Thant at United Nations Headquarters, September 2-3, 1968, at the request of the United Nations Economic and Social Council. Delegations from 87 countries participated officially in the conference; and delegations from 9 other countries, 7 U.N. affiliated organizations, and 18 nongovernmental international organizations attended as observers.

In addition to manpower needs, the agenda of the conference focused attention on the place of social welfare programs in national development, government responsibility for social welfare, and international cooperation for social welfare. While each of these subjects received detailed attention in one of the four Technical Commissions in which the conference divided, their interdependence was made abundantly clear in the debates in the Commissions and the plenary sessions as well as in the U.N. technical papers and country position papers prepared for the conference in advance.

An underlying assumption of the conference, explicitly stated by the chief of the U.S. delegation¹ as well as by representatives from other countries, was that the development of nations

depends on the well-being of the human beings within them, especially children and their families, and that, therefore, national planning must contain a large element of social welfare planning, focused sharply on the development of programs to strengthen family life. Nearly all the delegations testified to a common obstacle in reaching this objective—an extreme shortage in persons trained to plan, run, and man the necessary social welfare programs. Thus many suggestions emerged for accelerating the preparation of people to participate in all levels of efforts for social welfare—policymaking, research, administration, supervision, direct service, and volunteer work.

The U.N. Secretariat had prepared a working paper, "Meeting Manpower Needs for Social Welfare." It underscored the need for governments to take responsibility for planning to build up the quantity and quality of manpower for social welfare programs; urged that such planning be incorporated in overall national plans for professional education and vocational training; and emphasized the need to train for interdisciplinary teamwork and the development of leadership for policymaking. It also pointed to the need for each country to develop a core social welfare curriculum closely related to the country's customs and socioeconomic conditions; and urged that international cooperation be focused on "in-

digenous training programs" and on strengthening regional facilities for advanced training.

A comprehensive policy

The emphasis on governmental responsibility for developing a comprehensive manpower policy for social welfare was reiterated in the Commission on Manpower, which I attended as an official observer. In the deliberations of this Commission, many of the delegates stressed the importance of training leaders in the social welfare field to exert leadership in overall government planning and operations. They pointed out that because national social and economic policies affect people's lives, leaders in the social welfare field could make an important contribution to national development if they were trained to play a major role in policy development and in the development of legislation. Delegates from Israel, the Philippines, and Peru especially stressed this point.

The members of the Commission on Manpower also gave a great deal of attention to the need for training indigenous workers for social welfare programs—that is, training persons from the areas to be served to carry out the needed services. It was repeatedly stressed that social welfare workers should receive their basic training within their own countries so that their

training would be geared to the countries' specific needs and an understanding of the customs and psychology of their people. Along with this emphasis went an emphasis on developing materials within each country drawn from experiences within that country.

On the whole, the discussions indicated that the current trend in most countries is to prepare "generalists" for social welfare services, using the schools of social work or other formal training facilities for this purpose and relying on the service agencies to provide through inservice training what specialized training the workers might need to carry out the agency's function.

Levels of personnel

Considerable interest was evinced, however, in identifying various levels of social welfare personnel according to the tasks performed and defining a specific recruitment and training program for workers at each level. This point was stressed by the delegate from India, who said that without such a plan the manpower resources for social welfare would be wasted. The delegates from the Philippines and from the United Arab Republic spoke for the need to include a training program for volunteers in any manpower training plan.

Recruiting as such did not receive the same proportion of attention as training, but when the subject did come up it was inevitably tied in with the need to upgrade salaries for all levels of social welfare personnel—a particularly serious problem in the countries with extremely limited financial resources. The delegate from Indonesia urged the allocation of a portion of each country's national budget for training and research in manpower needs, including manpower for social welfare programs.

"Social welfare" within this conference may have had different meanings to different delegations, but on the whole the definition seemed to be broad enough to encompass any activity focused specifically on preventing or dealing with the problems that disrupt people's lives and, therefore, requiring a knowledge of people's needs and ways of meeting them. This core of knowledge many delegates seemed to see as essential for workers at all levels of service, with additional training superimposed according to discipline, specialty, and

degree of responsibility to be assumed.

Thus, the delegate from the Union of Soviet Socialist Republics stressed the need for training health workers, as well as the need for special courses for physicians and teachers who become involved in social welfare activities. The Mexican delegate stressed the need for involving health educators and agricultural advisers in social welfare training sessions. The delegates from Malaysia and the U.A.R. stressed the need for multipurpose workers. The Israeli delegate stressed the need for training rehabilitation workers. The Jordanian delegate stressed the need for training geared specifically to the refugee problem.

The political structure and degree of economic development of the country, of course, affected the particular emphases of the delegations. The delegate from the U.S.S.R., for example, recommended that all training be done at state expense. The Australian delegate stressed the importance of voluntary agencies participating in a country's development of a manpower plan. Several delegates, including those from Saudi Arabia, the U.A.R., and Indonesia spoke for international cooperation to help countries with their training problems through the establishment of special regional training facilities and through regional or subregional seminars.

International help in training persons for service in the social welfare field was called for especially in relation to higher level workers—the policy makers, planners, and administrators. Some delegates recommended exchange programs, but for such decision makers only. Greater stress, however, was put on the provision of technical assistance to countries to help them build up their own training facilities and programs. Regional and subregional cooperation for training was particularly stressed, the feeling seeming to be that the nations within a region were likely to have similar problems and to understand each others' needs more than nations in disparate parts of the world.

U.S. participation

The United States had no voting delegate in the Manpower Commission, but its two official observers at the Commission meetings were given an opportunity to express the U.S. point of view. We strongly supported the recommenda-

tions in the Secretariat's working paper on manpower for the assumption by government of responsibility for the sound development of social welfare services; put a high priority on rapid expansion and improvement of education for social welfare at a succession of levels, including formal training programs for auxiliary workers, graduate education for professional workers, and continuing inservice training for all levels of personnel; recommended reorientation of social welfare education to impart skills for helping people to work cooperatively to improve living conditions and make social institutions more relevant to current needs; stressed the importance of the wider use of nonprofessional workers and volunteers; urged the development of national and regional plans of study, conferences, and exchange of faculties and material in the social welfare field; urged that the field of social welfare be represented on the central planning bodies concerned with overall manpower needs; stressed the importance of data collection and analysis on a national or regional basis to assess manpower needs for the social welfare services and the kinds of manpower suitable for carrying out social welfare tasks, and urged that the United Nations provide technical assistance in this regard; and supported the U.N.'s emphasis on concentrating international cooperation on building up indigenous training facilities and teaching materials within each country and establishing regional facilities for advanced training.

Universities' role

We pointed to the need for professional education for social welfare at the master's level to provide the necessary leadership, and made a clear distinction between training workers for any level of social welfare service and training technical assistants in the fields of health, economic development, and agriculture—a distinction not always made clear by other delegates.

Other delegations also stressed the role of universities in promoting and protecting the quality of social welfare manpower. The delegate from Peru, for example, emphasized the university's role in developing research in manpower needs and educational methods as well as for developing resources for training. The delegate from Israel

pointed to the need to protect the quality of manpower at all levels of service and suggested that nations establish registration and licensing systems for persons trained for social welfare service.

Recommendations

In its report to the plenary session, the Commission on Manpower recommended the adoption by governments of a central manpower system with social welfare as a component, the establishment of training programs for various levels of social work personnel, the provision of better salaries and working conditions to increase the prestige of occupations in the social welfare field, the involvement of experts from the field of social welfare in high governmental planning, the development of training materials within the areas in which they are to be used, the establishment of training facilities within

each country, and the international development of regional and subregional training and research centers.

After the discussions of the Commissions' reports, the conference adopted 29 recommendations.² These were forwarded to the Economic and Social Council with the request that they be submitted to the twenty-third session of the United Nations General Assembly. Five of these recommendations concern manpower needs for social welfare. In brief, they urge that—

- The provision of qualified personnel for all levels of social welfare service be made a major concern of governments.

- Governments assess the particular requirements for such personnel in their countries in relation to total manpower needs, with attention to both rural and urban areas.

- Special emphasis and international help be given to the preparation of

leadership for planning and implementing social welfare programs adapted to the specific conditions of each country.

- Emphasis in social welfare training programs be put on the preparation of indigenous teachers responsive to local conditions, and on the production of training materials drawn from the experience in the country.

- Training programs be geared to facilitating the flexible use of all levels of social welfare manpower and preparing workers for teamwork with members of related occupations; curricula be periodically reviewed; and regional cooperation in new training experiments be encouraged.

¹ Cohen, W.: The developmental approach to social challenges. *Children*, November-December 1968.

² United Nations, Economic and Social Council: Report of the International Conference of Ministers Responsible for Social Welfare, October 7, 1968. E/4590.

guides and reports

EDUCATION AS THERAPY: suggestions for work with neurologically impaired children. Ruth Mallison. Special Child Publications, 4535 Union Bay Place, NE., Seattle, Wash. 98105. 1968. 166 pp. \$3.50.

Describes methods for use by special educators in evaluating and helping children with neurologically based learning difficulties.

CLASS AND ETHNIC DIFFERENCES IN THE RESPONSIVENESS OF PRESCHOOL CHILDREN TO COGNITIVE DEMANDS. Margaret E. Hertzog, Herbert G. Birch, Alexander Thomas, and Olga Aran Mendez. Society for Research in Child Development, The University of Chicago Press, 5750 Ellis Ave., Chicago, Ill. 60637. 1968. 69 pp. \$3.

Compares the behavior in response to demands made in intellectual testing of 3-year-old children of Puerto Rican unskilled and semiskilled workers and

3-year-old children of business and professional persons born on the U.S. mainland.

MULTIPLY-IMPAIRED BLIND CHILDREN: a national problem. Milton D. Graham. 1968. 82 pp. \$1.50.

NO TIME TO LOSE: a symposium. Pauline M. Moor. 1968. 53 pp. \$1.35. American Foundation for the Blind, 15 W. 16th St., New York, N.Y. 10011.

The first reports the results of a 1966 survey on multiply-impaired blind children in the United States; the second, a 1964 seminar on methods of teaching such children.

HOUSING FOR EARLY CHILDHOOD EDUCATION: centers for growing and learning. Association for Childhood Education International, 3615 Wisconsin Ave., NW., Washington, D.C. 20016. 1968. 84 pp. \$1.50.

Offers guidelines for designing nurs-

ery schools and kindergartens with indoor and outdoor facilities, space, equipment, and materials adequate for maximum growth and learning in preschool children.

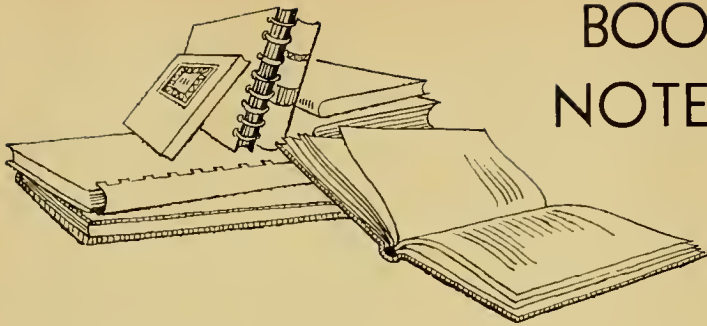
BUILDING TOGETHER: a selected reading list. American Library Association for United Community Funds and Councils of America, Inc., 345 E. 46th St., New York, N.Y. 10017. Revised 1968. 30 pp. 50 cents. Special rates for orders of more than 10 copies.

Lists 207 titles of books for boys and girls that illustrate some phase of social responsibility.

AN OVERVIEW OF UNDERGRADUATE EDUCATION IN SOCIAL WELFARE: past issues, current developments, and future potentials. Arnulf M. Pins. Council on Social Work Education, 345 E. 46th St., New York, N.Y. 10017. 1968. 23 pp. \$1.

Examines the objectives and curriculum of undergraduate programs in social welfare and the role of these programs in meeting social work manpower needs.

BOOK NOTES



EARLY CHILD CARE: the new perspectives. Edited by Laura L. Dittmann. Foreword by Caroline A. Chandler and Anne DeHuff Peters. Epilogue by Reginald S. Lourie, Atherton Press, New York. 1968. 385 pp. \$8.95.

A result of a series of four conferences of research psychologists, pediatricians, psychiatrists, and other specialists in child development, this book has what the editor calls a "double focus": (1) to identify what is known about the developmental needs of children under 3; and (2) to present ways of applying this knowledge in child-care programs—those that substitute for the child's own family, those that supplement the care the child receives at home, and those that concentrate on helping the family itself improve its quality of care. Its 14 papers (by 13 authors) are presented in four sections: I. A New Look at the Young Child: Development and Individuality; II. Translating Child Care Goals into Procedural Terms; III. Contemporary Programs and Strategies; and IV. New Research in the Prevention of Culturally Determined Retardation.

Part I contains papers discussing the development of the child in each of his first 3 years, the way the factors in the child's environment affect and are affected by the child, and how these environmental factors can be manipulated by the caretaker to affect the child's development.

Part II contains papers discussing ways of assessing the needs of specific children and the responses to be expected from manipulating the environment in specific ways.

The papers in part III describe and discuss the implication for program planning of patterns of child care

among the poor in this country and group care programs for infants and young children in other countries.

Part IV presents reports on four longitudinal research projects in the group care of very young children.

In an epilogue Reginald Lourie, M.D., calls for programs to prevent early distortions in the development of children and for the training of professional and subprofessional workers to recognize the special needs of individual babies and young children. He proposes a network of community centers for children and parents similar to the parent and child centers now being established with support from the Office of Economic Opportunity.

The conferences providing the foundation for the book were convened between April 1964 and October 1965 under the joint sponsorship of the National Institute of Mental Health, the Children's Hospital of Washington, D.C., and American Public Health Association, Maternal and Child Health Section, Committee on Day Care.

DECISION-MAKING IN POVERTY PROGRAMS: case studies from youth-work agencies. Melvin Herman and Michael Munk. Columbia University Press, New York. 1968. 181 pp. \$7.50.

Through 20 case studies, the authors here illustrate administrative and operational decision-making in anti-poverty programs serving unemployed, disadvantaged young people. They present five cases under each of the four major heads—planning, operation, organizational change, and research and evaluation. Most sections of the country and large and small cities, suburban towns, and rural areas are represented.

The majority of the cases presented were drawn from community youth work programs financed through the Neighborhood Youth Corps, but some are drawn from the Job Corps program. Among the specific problems they deal with are racial imbalance, a high drop out rate, the supervision of civil service employees stationed in a private agency, and conflicts in service and research demands. Each case includes background material, descriptions, and discussions of the setting of the program, the problem to be solved, the way in which it was approached, and the consequences of the decision.

The 20 cases were selected, collected and prepared by the Institutes and Curriculum Development Project of the Center for Study of the Unemployed of the Graduate School of Social Work at New York University with support from the Office of Juvenile Delinquency and Youth Development, U.S. Department of Health, Education, and Welfare.

THE CAUSES OF BLINDNESS IN CHILDHOOD. G. R. Fraser and A. I. Friedman. The Johns Hopkins Press, Baltimore. 1968. 245 pp. \$12.

This book reports on a study of the causes of blindness in 776 children registered as blind in England and Wales. The study was conducted by the Department of Research Ophthalmology, Royal College of Surgeons, London for the British Foundation for Research into the Prevention of Blindness. The group represents almost one-fourth of the children registered.

The children in the study were born between 1941 and 1962. Those of school age represented all grade levels, but children who were entirely untrainable because of mental retardation were excluded. Clinical examinations, family histories, medical, school, and social records, and other available information about each child were used to help establish the probable cause of blindness. From such diagnoses, the authors define the roles and relative importance of heredity and environment in childhood blindness.

Each chapter deals with a specific cause of blindness. Chapters are grouped into sections on genetically determined causes, prenatally acquired causes, perinatally acquired causes, and postnatally acquired causes. The authors trace 42 percent of the blindness in the group studied to genetic causes, and 50

percent to environmental causes—6 percent from prenatal causes, 33 percent from perinatal causes, and 11 percent from postnatal causes. Another 8 percent they found due to a complex combination of genetic and environmental factors.

The authors point out the role that premature births have in causing visual handicaps as well as in causing mental retardation, cerebral palsy, and deafness. They predict that acquired blindness in children will "probably" decrease with further advances in perinatal and obstetric care.

The prevention of genetically determined blindness is a long-range goal of research. The authors state that genetic counseling may help to limit propagation of blindness in the future, but individual genetic entities must first be identified to detect asymptomatic carriers.

POPULATION AND PEOPLE. Edward G. Stockwell. Quadrangle Books, Chicago, Ill. 1968. 307 pp. \$6.95.

This book seeks to impart to the reader an appreciation and understanding of the close relationship between population trends and many of the political, economic, and social problems of present-day American society and to stimulate the reader to pursue further the study of demographic developments. To this end, the author describes some significant population trends in the United States against the background of a brief discussion of international population trends and provides references for additional reading on each of the topics presented.

The aspects of population the author examines are mortality, fertility, and migration (the basic processes of population change) and population size and growth, composition, and geographic distribution (the major variables in population structure). Within the framework of each of these elements of demography, he directs his discussion toward the underlying determinants and socioeconomic consequences of the trends. More specifically, he considers the relation of population trends to such problems as poverty, race conflict, overpopulation, birth control, and urban congestion and offers some suggestions or possible solutions.

In regard to the United States population composition or structure, the author discusses such characteristics

as age, sex, marital status, color, and nativity. He treats the social significance of each of these characteristics, the historical trends leading up to the present situation, and the associated problems.

THE BATTERED CHILD. Edited by Ray E. Helfer and C. Henry Kempe. The University of Chicago Press, Chicago, Ill. 1968. 268 pp. \$12.50.

This collection of 11 papers—some original and some previously published in professional journals—discusses the historical, demographic, medical, psychiatric, social, and legal aspects of child abuse. The editors, Ray E. Helfer, M.D., and C. Henry Kempe, M.D., have taken a multidisciplinary approach in presenting information on child abuse which they hope will be used "to change the fate of abused children and their parents."

A psychiatric study of 60 families in which significant abuse has occurred in children under 3 is described by Brandt F. Steele and Carl B. Pollock, University of Colorado psychiatrists. They have found that such parents, many of whom were in their 20's, represent a random cross section of the general population as to education, income, and housing. The authors have observed that the specific pattern of childrearing in parents who abuse their children includes excessive demands for submissive behavior and prompt obedience, constant criticism, and a corresponding parental disregard of the infant's own needs and abilities. These parents had been subject to high expectations, plus a lack of emotional response to their needs—or a lack of "mothering"—in their own childhoods, and subsequently subjected their own children to the same kind of parent-child interaction. Dr. Steele and Dr. Pollock report that in many cases after treatment of the parent, a change in the style of parent-child interaction eliminated the danger of physical harm to the child.

PAID SERVANT. E. R. Braithwaite. McGraw-Hill Book Co., New York. 1968. 219 pp. \$4.95.

This first-person account of the experience of a Negro schoolmaster from British Guiana (now Guyana) as a child welfare worker in England with immigrants centers on the author's efforts to find a foster or adoptive home for a

4½-year-old "coloured" boy, Roddy. The child, apparently partly Mexican-American, was rejected by both Negro and white couples as "not one of our kind." This attitude was only one of the obstacles to his efforts. Officials often brought his work to naught, rejecting one couple as not warm enough, delaying so long another couple gave up their request. In the end, he was able to place Roddy with a white family as a foster child to the satisfaction of all.

Between recounting events in Roddy's story, the author describes other cases he handled. Though he was assigned mostly to cases involving "coloured people," he found that his success was seldom due to his color.

for parents

YOUNG PEOPLE AND CRIME. Arthur H. Cain. The John Day Co., 200 Madison Ave., New York, N.Y. 10036. 1968. 154 pp. \$3.95.

HOW TO ADOPT A CHILD. Robert A. Farmer. Arco Publishing Co., 219 Park Ave. South, New York, N.Y. 10003. 1967. 131 pp. \$4.95.

THE LAUGHTER AND TEARS OF CHILDREN. Marilyn Bonham. The Macmillan Co., 866 Third Ave., New York, N.Y. 10022. 1967. 213 pp. \$4.95.

SPEECH AND LANGUAGE DELAY: a home training program. Second Edition. R. Ray Battin and C. Olaf Haug. Charles C Thomas, 301-327 E. Lawrence Ave., Springfield, Ill. 62703. 1968. 77 pp. \$5.50.

A PRIMER FOR PARENTS: a child psychiatrist's advice on raising emotionally healthy children. Jerome S. Fass, M.D. Trident Press, Rockefeller Center, 630 Fifth Ave., New York, N.Y. 10020. 1968. 192 pp. \$4.95.

THE RETARDED CHILD: a practical guide to the important recent advances in the care and rehabilitation of the mentally handicapped child. Nancy W. Faber. Crown Publishers, 419 Park Ave. South, New York, N.Y. 10016. 1968. 308 pp. \$5.95.

HERE and THERE



Federal legislation

On October 16, President Johnson signed into law the Vocational Education Amendments of 1968. (P.L. 90-576).

The Act reorganizes the entire body of Federal vocational education laws to encourage the upgrading of vocational education programs and gives particular attention to the needs of disadvantaged persons.

The amendments authorize the Commissioner of Education to make grants to the States for—

- General vocational education programs, arrangements with public and private organizations and institutions to provide vocational training; and related activities such as teacher training and supervision, program evaluation, experimental programs, the development of instructional materials and improvement in administration. No less than 15 percent of the funds made available for such programs are to be used for persons who have academic or economic handicaps; 10 percent for persons otherwise handicapped; 15 percent for persons who have finished or left high school.

- Educational programs in home economics and consumer education with special consideration to social and cultural conditions and needs in economically depressed areas.

- Cooperative work-study vocational education arrangements designed jointly by school and employer.

- Work-study programs which provide part-time employment in public institutions and in private industry for students enrolled full-time in vocational education programs.

The Commissioner is also authorized to make direct grants to institutions of higher education, State Boards of Education, public and private agencies,

or local educational agencies (depending on the program) for—

- Research in vocational education and related personnel training, experimental programs, demonstration projects, the development of new curricula; and projects to develop new careers and occupations in other than professional work in such fields as mental and physical health, crime prevention and correction, welfare, education, municipal services, child care, and recreation.

- The development and dissemination of curriculum materials.

- The construction, equipment, and operation of residential schools of vocational education for young people between 15 and 21, especially to meet the needs of urban areas with large numbers of school dropouts.

- Cooperative arrangements for the training or retraining of experienced vocational education educators.

The Act directs the Commissioner to appoint a National Advisory Council on Vocational Education and requires the States receiving Federal funds for vocational education to establish similar advisory boards.

The Act also directs the Commissioner to study the feasibility of transferring the operation of the Job Corps from the Office of Economic Opportunity to State or joint Federal-State operation; and it directs the President of the United States to make a special study of whether the administration of Project Headstart should be transferred from OEO to another agency of government.

On October 16, President Johnson also signed into law the Higher Education Amendments of 1968. (P.L. 90-575). This Act amends the various education acts to extend the reach of their pro-

grams and to provide for new programs.

Among the new programs it authorizes are Federal assistance to institutions of higher learning for—

- Cooperative education programs of alternative full-time study and full-time work.

- Special services for disadvantaged students in need of remedial counseling or other services because of deprived backgrounds or other handicaps, such programs to be supported by grants to institutions or groups of institutions.

- Networks for knowledge provided by grants to groups of institutions of higher education for developing curricular strengths.

- Education for public service including the preparation of graduate or professional students to enter public service, and research in or demonstration of improved methods of education for the public service; to be supported by grants to or contracts with institutions or groups of institutions.

- Improvement of graduate education through grants to institutions having doctoral programs for the strengthening of graduate faculties, the acquisition of equipment and the strengthening of administration, such grants to be allocated with a view of regional balance.

- Law school clinical experience program consisting of grants to law schools for establishing or expanding programs to provide clinical experience to law students.

The Act transfers the Upward Bound program, to promote post high school education for inadequately prepared disadvantaged students, from the Office of Economic Opportunity to the Office of Education, tying it in with the Talent Search program and the new program of special services for disadvantaged students.

The Act also amends the National Defense Student Loan program to allow forgiveness of 15 percent of a loan for each year the borrower teaches in schools in which 50 percent or more of the children enrolled are from low income families.

On September 30, President Johnson signed into law the Handicapped Children's Early Education Assistance Act. This Act authorizes the Commissioner of Education to make arrangements through grants, contracts, or otherwise for experimental, preschool, and early

education programs for handicapped children. Such programs are to be designed to facilitate the intellectual, emotional, physical, mental, social, and language development of children; encourage the participation of the children's parents; and acquaint the community with the problems and potentialities of handicapped children.

The term "handicapped children" is defined to mean children who are mentally retarded, hard of hearing, deaf, suffering from speech defects, visually handicapped, seriously disturbed emotionally, or crippled or who because of other health impairments require special education and related services.

Genetic effects of LSD

After studying 66 women of child-bearing age who had voluntarily taken the psychedelic drug, LSD, from 1 to 176 times before or during pregnancy and who had exhibited definite genetic damage of the chromosomes, a sociomedical team at George Washington University in Washington, D.C., reported in November that there had been 35 abortions and 25 births of normal-appearing babies in these LSD users during the previous 18 months. Four fetuses that were obtained through therapeutic or spontaneous abortions showed defects of the central nervous system so severe that normal development would have been impossible.

Of the 25 babies, 22 have shown chromosome breakage, the same type of damage found in their mothers. Four have congenital defects not considered serious—hernias, birthmarks, or scars. The babies have been studied at 2 weeks, 6 weeks, 3 months, and then at 3-month intervals.

Most of the young women in the study were from middle-class homes in the suburbs of Washington, D.C. Their ages ranged from 15 to 26. About 80 percent were single, pregnant for the first time, and under 21 years of age. The research team is also following five pregnant girls who have never taken LSD, but whose husbands or boy friends have used the drug.

The long-range consequences of the drug on human reproduction are yet to be proved, but the findings raise the question of possible genetic damage to the children and grandchildren of LSD users—both men and women—according to Cecil B. Jacobson, M.D., genet-

icist in the George Washington Medical School Department of Obstetrics and Gynecology, who is directing the 2-year study for the Bureau of Drug Abuse and Control of the Department of Justice. His associates are Chesten Berlin, M.D., a pediatrician, and Valerie M. Stubbs, medical sociologist.

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The relation between the use of LSD during pregnancy and fetal damage is being studied under a 2-year research project, recently begun at Stanford Research Institute, Menlo Park, Calif., under a grant from the National Institute of Mental Health. The study, conducted by Edward T. Uyeno, an experimental psychologist, involves injection of five groups of pregnant rats with varying doses of LSD and examination of their offspring for signs of abnormality. The purposes of the project are to help answer the question of whether offspring are deformed physically or neurologically when a pregnant woman takes LSD and—if LSD is found to produce deformities—to determine correlations between dosage and extent of neurological damage.

For the poor

The problems of low-income, inner-city families are influencing the current planning, programing, and funding of 150 local voluntary family service agencies, according to a nationwide survey conducted by the Family Service Association of America in the spring of 1968. About 217 agencies responded to a questionnaire sent to the organization's 341 local affiliates. Many of the agencies reported that they are already deeply involved in providing a wide range of services to families in areas of poverty; and 100 reported being encouraged to take this direction by offers from their local United Funds to give priority in fund allocations to innovative programs in the inner city.

Twenty-five additional agencies reported that they were reordering their priorities to meet potentially explosive innercity situations not now regarded as "critical," although their United Funds had not encouraged such efforts. Another 42 agencies, most of them in suburban areas or relatively small cities, reported that they faced no "innercity problems" and they did not plan any changes in their policies or programs.

FSAA's affiliates reported conducting 248 special projects in 1967—the great majority of them in innercity neighborhoods. They fell in three general classifications: participation in the operation of multiservice centers, neighborhood houses, day care centers, and similar facilities; the provision of consultation to sponsoring agencies of innercity programs, such as Headstart, and training nonprofessional staff members and volunteers to work in such projects; and outreach casework service and family life education.

For example, the affiliates have undertaken such projects as the creation of a neighborhood center for residents of a housing project, with emergency help available 24 hours a day, and a training program for low-income persons employed to staff the center; establishment of two "family centers" offering parent education, crisis intervention, and new approaches to service; administration of a cooperative daytime center for young unmarried mothers sponsored by a Board of Education, City Health Department, Visiting Nurses Association, YWCA, and a hospital with funding from the Children's Bureau; location of a permanent office in the ghetto area, with allocation of 30 percent of an agency's total professional hours to this service; and administration and supervision of a Parent and Child Center funded by the Office of Economic Opportunity.

The affiliates participated in 168 projects supported by public funds and 80 projects supported by funds from private foundations and agencies.

Volunteers

During the past 3 years, the Toberman Settlement House in San Pedro, Calif., has developed a volunteer program which in 1967 provided some service from volunteers to nearly half the families assisted by the agency's welfare services division, a casework unit established to help poverty-stricken families with their individual needs. The program is under the direction of Ruth Britton.

Trained and supervised by professional social workers on the agency's staff, the volunteers are supplied by Church Women United in the San Pedro area, other women's organizations, and California State College at Long Beach. They consist of three

kinds: home visitors, transportation providers, and tutors.

After a staff member determines that a family needs special help, a volunteer visitor or tutor, as the occasion warrants, is assigned to it and remains that family's volunteer. The transportation providers, on the other hand, are on call at assigned hours to serve whatever families need help in getting to clinics, agencies, and the like. All volunteers act in a liaison capacity between the family and the agency, notifying the staff of family needs and the family of available services. The home visitors provide the family with emotional support, give evidences that someone cares, and lend a listening ear. Sometimes they accompany a mother to school to discuss a child's problems with his teacher. Sometimes they make suggestions for organizing housework or helping with shopping and meal planning, teach simple sewing, and encourage the mothers to use the resources available for improving their homes—for example, enrolling in a mothers' club or sewing class at the settlement house.

The tutors who include both former teachers and advanced Spanish students at California State College explain class assignments to Spanish-speaking children and help them with their English. They also help other children who are having trouble with school work.

During 1967, a total of 25 volunteers served 190 families through the agency.

Rubella

The first field trials of a rubella vaccine during an actual epidemic of the disease, conducted under the auspices of the U.S. Public Health Service in Taiwan in 1968, show that the vaccine is more than 90 percent effective, according to the director of the field trials, J. Thomas Grayston, M.D., chairman of the University of Washington's Department of Preventive Medicine. The medical team gave a single injection of live attenuated vaccine to each of 3,269 school boys in Taiwan and used about 6,000 more school boys as "controls."

The field trials are part of the current intensive effort by the National Institutes of Health, eight pharmaceutical companies, 12 university medical centers, and four industrial research laboratories to perfect a safe, reliable rubella vaccine to avert the next U.S.

epidemic, which is expected in the early 1970's. Activities are being coordinated by the National Institute of Allergy and Infectious Diseases (NIAID) with the Division of Biologics Standards and the National Institute of Neurological Diseases and Stroke also cooperating. Field trials among 10,000 school children in 12 communities in the United States are now under way or have been completed and are being evaluated. The trials involve strains of a live attenuated vaccine (HIPV-77) developed by NIH's Division of Biologics Standards in 1966. [CHILDREN, September-October 1966, p. 204.] Other vaccines are also being studied under NIAID-contracted research.

Because it involves a live virus, HIPV-77 is not recommended for vaccinating pregnant women who risk severe damage of the fetus if they contract rubella. When research began in 1965, emphasis was placed on developing an inactivated rubella vaccine suitable for administration to pregnant women. Although a number of obstacles—such as inability to achieve high yields of virus in acceptable tissue culture systems and loss of antigenicity during inactivation—have so far prevented development of an effective inactivated vaccine, research is continuing.

The U.S. medical team in Taiwan conducted the field trials of HIPV-77 with boys in the first through the fourth grades in two schools in Taipei and two schools in Taichung. In addition to the boys receiving rubella vaccine, 3,010 other boys received an injection of Salk polio vaccine, which does not affect the course of rubella. Other boys in the trials received no vaccine. The study found that if a boy had been exposed to rubella before vaccination, he received no protection. About 50 percent of the unvaccinated children developed rubella during the epidemic.

The length of time for which the rubella vaccine offers protection is not yet known, but will be determined by checking vaccinated children in Taiwan periodically.

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Under a new program designed to meet the needs of deaf-blind children—some 1,250 of whom owe their condition to the rubella epidemic of 1964-65—the Office of Education is supporting the establishment and operation in 1969 of at least eight regional centers to offer

comprehensive services to such children and their parents. The centers will be operated by public or nonprofit private organizations and under grants from the Bureau of Education for the Handicapped. Their services will include diagnosis, evaluation, and education of the children and consultation to parents and teachers. The centers may also conduct research and experimentation on new ways to reach deaf-blind children and to help their parents work with them, and may train persons to work in special education programs for the deaf-blind.

The provision of Federal aid for such centers was authorized for 3 years by the 90th Congress in a revision of Title VI of the Elementary and Secondary Education Act (P.L. 90-247) signed by the President in January 1968.

Foster care

For the past 3 years, the Girl Scouts of DuPage County (Ill.) Council and the Wisconsin Department of Health and Social Services, Division of Family Services, have cooperated in providing a camping experience to girls in foster care who have had difficulty in getting along with other children. The project which began with a 4-day program in a special unit for 12 foster children in 1966, has been expanded to allow foster children to attend as regular campers while continuing the special unit for girls not ready for the regular camp experience.

Most of the girls included in the project have been in foster care in the Eau Claire district of Wisconsin. In 1966, while at camp, they lived in a unit called Cheskamae, they ate their meals with the Girl Scouts, but were provided with a separate camp program designed to help them get along with others. The Girl Scout Council furnished the camp facilities and staff while the State agency furnished consultation from its group worker and the girls' caseworkers and paid for food and equipment through Federal child welfare services funds. The second and third years, the Scout Council set the cost for the girls in the Cheskamae unit at half the normal fee for other campers and the expense was provided for in the regular foster care budget.

For the girls in foster care, the camp experience is designed to offer a chance to improve their ability to get along

with other girls and with adults, to develop interests that will lead to participation in school and community activities, and to have fun. For the foster care caseworkers it is designed to provide information about the girls' behavior with other children and their ability to adjust to new situations gained from firsthand observation; insight into the relations between foster parents and the child; and a chance to recognize latent leadership ability. For

the Girl Scouts, it is designed to offer a chance to meet and become friends with girls who had had experiences different from their own.

According to Mary Julia Denton, group work consultant for the Wisconsin Division of Family Services, and Jackie Sanders, executive director of the Girl Scouts of DuPage County Council, the project has achieved these purposes in regard to many of the girls.

Caseworkers have noticed that some

girls have adjusted better to their foster homes after they had become friends at the camp with other girls who were also in foster care. As a result of observations made during the camping period, one girl was moved to a new foster home, one girl was adopted ahead of schedule, and another was given psychiatric help.

The girls' stays at the camp were lengthened to 1 week in 1967 and 2 weeks in 1968.

films on child life

Charges for rental or purchase may be obtained from distributors.

THE ALLEN CASE: A TEACHING FILM. A group of 5-minute films; sound; black and white; purchase.

Demonstrates the process of providing social work service to an AFDC mother with four children separated from her husband at a period of severe stress. The five films show four excerpts from interviews during a 2-month period. They are designed to increase skills of baccalaureate degree social workers in treatment-oriented interviewing. A teaching manual accompanies the film.

Audience: Beginning social workers in public and private social agencies which offer individual services, supervisors, staff development personnel as well as other agencies which offer neighborhood or community services, and schools of social work.

Produced by: The former Bureau of Family Services, now part of the Social and Rehabilitation Service, of the U.S. Department of Health, Education, and Welfare.

Distributed by: Du Art Film Laboratory, Inc., 215 W. 55th St., New York, N.Y. 10019.

L.S.D. TRIP—OR TRAP! 20 minutes; sound; black and white or color; purchase.

Gives information about LSD, from

the viewpoint of a 17-year-old boy who does not take the drug although his best friend does.

Audience: Junior and senior high school and college students.

Produced by: Sid Davis Productions.

Distributed by: Sid Davis Productions, 2429 Ocean Park Blvd., Santa Monica, Calif. 90405.

MATERNITY HOSPITAL ROUTINE.

15 minutes; sound; color; preview-before-purchase, purchase, or rent.

Explains the procedures in a hospital maternity ward and labor room and how pre-delivery tests are made. Depicts the roles of physicians and nurses during delivery, methods of identifying babies, and the care given mothers in the recovery room.

Audience: Expectant parent classes.

Produced by: Moreland-Latchford Films.

Distributed by: Sterling Educational Films, Inc., 241 E. 34th St., New York, N.Y. 10016.

THE POPPE PROJECT: behavior shaping with the severely retarded. 23 minutes; sound; black and white; rent, purchase, or loan for preview-before-purchase.

Documents the progress of eight severely retarded girls, aged 11 to 23, in feeding themselves, dressing, playing,

and interacting with each other after being given the concentrated attention of one nurse responsible for stimulation and training.

Audience: Restricted to professional audiences for medical, psychological, or mental health education, training, and research. Nurses, psychologists, physicians, technicians, public health workers, teachers, and others responsible for the direct care of retarded patients.

Produced by: School of Nursing, San Francisco Medical Center, University of California.

Distributed by: Films Sales Distribution, University of California Extension Media Center, 2223 Fulton St., Berkeley, Calif. 94720.

FROM THIS DAY FORWARD. 28½ minutes; sound; black and white; purchase or rent.

Depicts an actual sequence of events in the lives of a young couple and their three small children, the problems they encountered, and their efforts to resolve them; and demonstrates their use of the counseling service of a family service agency in individual, joint, and group interviews. Includes a summary by Margaret Mead.

Audience: Staff members of social agencies; parent education, undergraduate college, and high school classes; and lay groups.

Produced by: KOGO-TV, Time-Life Broadcast, Inc., San Diego, Calif., for the Family Service Association of San Diego.

Distributed by: Association Films, Inc., 600 Madison Ave., New York, N.Y. 10022, and its branch offices.

IN THE JOURNALS

Comprehensive care

Describing the elements of comprehensive health care for children in the October 1968 issue of *Public Health Reports*, Helen M. Wallace, M.D., and four of her associates at the University of California School of Public Health outline the essentials for reaching four objectives of comprehensiveness: optimal care; coordinated care; accessible care; and continuous care. ("Comprehensive Health Care of Children.")

Optimal care, according to the authors, involves attention to medical, dental, social, emotional, educational, vocational, recreational, and nutritional needs, and requires an integrated interdisciplinary team of professional persons and aides. It also requires team planning for the whole family as a unit and attention to the prevention of ill health, through health education of children and parents, family life education, genetic counseling, and family planning services.

Coordinated care, as described by the authors, involves the integration of preventive, curative, and rehabilitative services under a single system of care, and requires relating the program closely to other community services, especially school health services, services for handicapped children, Headstart, and Medicaid.

Accessible care, say the authors, requires providing services close to where the children live, on a 24-hour day, 7-day week basis. Such care, the authors point out, does not necessarily require the provision of all care from the same place at the same times, but it does require the establishment of an effective system of reporting between the providers of service. It also involves home visiting by a public health nurse and elimination of such deterrents to the use of clinic services as impersonal approach, long waiting periods, and requirements for repetitious visits.

Continuous care, the authors point out, means following the child through-

out his infancy, childhood, and adolescence whether or not family moves from the original neighborhood of service.

The authors also call attention to the importance of broad community representation in program planning, the integration and improvement of existing community services, the establishment of facilities to fill service gaps, the establishment of record systems to provide for continuity in care, plans to extend services to all in need of them, research to establish the extent of need, and preservice and inservice training of staff.

Parental consent

Exceptions to State laws requiring parental consent to medical treatment of minors are reviewed briefly in the November 1968 issue of the *American Journal of Nursing*, by Nathan Hershey, research professor of health law, University of Pittsburgh School of Public Health. ("Minors and Consent.") Pointing out that traditionally the government is reluctant to intervene in the relationship between parents and children, he maintains that the question of when consent is necessary is often confusing—for example, when parents are not readily accessible to give consent to needed treatment, or when informing the parent does not seem desirable from the point of view of the welfare of the minor.

Some States, the author notes, make exceptions for unmarried pregnant minors, and allow them to consent to their own hospital and medical care without a parent's consent. They also accord parental responsibility to an underage parent, whether married or unmarried, for consent to treatment of their offspring. Married or self-supporting minors in many States are regarded as "emancipated minors" and as such are exempt from the requirement for parental consent, the author reports. He also points out that some States permit physicians to examine and treat a

minor for venereal disease with the minor's consent but without consent from or notification of his parents.

The author notes that in recent years some States have passed laws allowing medical procedures to be performed on children in emergencies without parental consent when delay would be damaging. One unresolved question, he says, is whether physicians can be called to account for treating a sick or injured child at the request of adults in whose temporary care the child has been left by his parents. He advises physicians and nurses who face decisions in this regard to consider the interests of the child as of paramount importance.

Musical chairs in AFDC

A number of recent studies have given evidence of a constant "game of musical chairs" among a sizable sector of the poor as families move on and off assistance rolls, using the Federal-State program of aid to families with dependent children as a substitute for income lost from sporadic, marginal employment, according to Genevieve W. Carter writing in the July-August 1968 issue of *Welfare in Review*. ("The Employment Potential of AFDC Mothers.")

The author, chief of intramural research of the Social and Rehabilitation Service, cites studies indicating that families whose applications for AFDC are rejected generally have the same characteristics as those accepted, are "indeed poor, as evidenced by the type of housing, health care, and clothing they have," and differ from the accepted families only in the "degree of disadvantage at the time of application." She reports evidence that among 30 to 50 percent of rejected applicants conditions deteriorate to the point of making them eligible for assistance within 3 to 6 months.

Citing studies that have shown that as many as 80 percent of women in AFDC caseloads have employment histories and that in many states a large proportion of them are working to supplement wages inadequate to meet their families' needs, the author suggests that the majority of mothers in the AFDC program expect and want to work. She names pregnancy, illness, child care problems, and the end of the job as the most frequent reasons for their intermittent episodes of dependency, which, she says,

will continue to occur as long as the job opportunities open to these mothers are a part of the irregular economy.

Raising a number of questions pertinent to policy development—such as whether young mothers susceptible to acute child care problems but with more training potential should be given preference in training programs over older mothers, and whether mothers with marginal income who are not receiving assistance should be excluded from the training and child care opportunities being planned—she suggests that before research can be helpful in decision-making, the goals of policy must be clear. And she asks: “Are the objectives to instill work ethics in the AFDC family, to contribute to the economy, to increase family income, or to offer a choice to the mother who is the family head?”

Living on AFDC

The results of a study to determine how well families are living who receive assistance under New Mexico's federally aided program of aid to families with dependent children (AFDC)

are reported in the October 1968 issue of the quarterly *Social Work*. (“By Bread Alone, and Little Bread: Life on AFDC,” by Gil Bonem and Philip Reno.) The authors, research associates in the Department of Economics, University of New Mexico, derived their findings from interviews about family expenditures conducted in April 1967 with 33 mothers in the AFDC program and from “secondary sources,” including a report of the Bureau of Labor Statistics, U.S. Department of Labor, on average consumer expenditures and income for the Western United States for 1960–61.

Their findings showed that while over 45 percent of the expenditures of the AFDC families went for food as against 24 percent for the average Western family, the average per capita expenditure for food in the AFDC families was \$234 per year (including the value of surplus commodities) as against the average per capita expenditure for food among Western families of \$417 per year. The \$4.50 per person average weekly food expenditure in the AFDC families was 10 percent below the per capita expend-

iture in the Department of Agriculture's economy food plan for adequate nutrition, adjusted for 1967 prices.

While the budgets on which the AFDC monthly payments were based (before a 5 percent reduction of the total amount budgeted) included an average of \$53 for rent at the time of the interviews, the AFDC families were actually paying an average of \$67 for rent, thus cutting into the amounts budgeted for other needs. Their expenditures for clothing averaged \$27 per person a year; their average family expenditure for durable consumer goods was \$44 a year as against \$400 per family in the country as a whole in 1962.

The authors report that the families on AFDC spent “a barely discernible amount” for recreation, personal care, and “other such pleasures that people find in life.” Maintaining that “the gap between ‘modest but adequate living’ and AFDC living” is widening, the authors point out that the AFDC payment in New Mexico decreased from \$32.37 per person in 1960–61 to \$30.67 in December 1967 in spite of sharp increases in living costs.

READERS' EXCHANGE

HERZOG AND SUDIA: *Implications or programs*

“Fatherless Homes—A Review of Research” by Elizabeth Herzog and Cecelia E. Sudia, which discusses the research on the effects on children of growing up in fatherless homes, is a timely and significant article [CHILDREN, September–October 1968].

The fatherless home has become a national and community issue as new strategies and programs have been devised for strengthening families and individuals in our inner cities and depressed rural areas.

The day-to-day experience of social workers, educators, and others has

seemed to support the classic view about the deleterious effects of growing up in a fatherless home. However, as the authors point out, the emphasis on the single causative factor—the absence of the father—has led to broad generalizations, reinforced, untested assumptions, and the acceptance of new stereotypes, which deflect our efforts to meet the needs of children. My own experience in the child welfare field confirms the validity of the authors' emphasis on the need to consider a cluster of variables, in assessing the effects on children of growing up in a fatherless home.

As the authors imply, there does not appear to be any basis for concluding

that fatherless homes *per se* have an adverse decisive effect on the development of children. Therefore, it is now imperative to reassess and modify the practice, theory, policies, and programs in the health, welfare, and educational fields that have been derived from this assumption.

The authors place proper emphasis on the failure of research workers to point out the other side of the coin: that the large proportion of children who grow up in fatherless homes do *not* show adverse effects; and that two-thirds of the children in poverty-stricken populations are growing up in two-parent homes, including many who show the same developmental and behavioral problems as children in fatherless homes. It seems to me that research efforts might be more fruitfully directed toward identifying family strengths, coping patterns, and the areas where children need additional supports.

My experience also confirms the importance of defining the social and com-

munity context in which family patterns develop and are maintained. Male unemployment and low-paying employment have tended to impinge negatively on the role performance of inner-city fathers and to weaken family life.

I have been concerned about the extent to which professional and community values impose negative sanctions upon fatherless families. For example, children must often admit to fatherlessness for institutional records; and for some community activities a child's participation is tied to the presence of the father. In contrast, the Scandinavian countries recognize the one-parent family and provide a healthy environment for the development of children through a broad, integrated system of social supports.

It is my earnest hope that administrators and practitioners will be led by this review of research to reassessment and change so that the programs will effectively supplement the mothers' efforts in one-parent families to meet their children's developmental needs.

Patricia Garland Morisey
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National School of Social Service
Catholic University of America
Washington, D.C.

For fatherless boys

Although it has provided stimulating reading, the article on fatherless homes by Herzog and Sudia omitted a significant aspect of treatment intervention when they imply that recognition is not given to the single-parent family "as a family form in its own right." I refer to the Big Brother agencies.

A Big Brother program is a basic child welfare service geared to strengthening the lives of children. Its help to the fatherless boy who lives at home is unique in recognizing that the child's problem may be connected to the lack of an adult male figure in the house. Mothers who request the service of a volunteer Big Brother attempt to fill a void in their son's lives.

Because there are one-parent families that experience parent-child problems requiring professional intervention, we have geared our program to help fatherless families through a combination of social work and volunteer services, in the following ways:

- To help the mother achieve a more realistic understanding of herself as a person, her parental role, and what she

can expect from an adult male volunteer to provide the child in the way of friendship—identifying with maleness, exposure to vocational interests, and experiencing various methods of relating through observation of the Big Brother.

- To help the mother reevaluate her goals, not only as a parent, but as a wage earner, a person with self-interests, a member of the community.

- To help the fatherless boy gain self-confidence and confidence in another human being who cares about him.

- To help the fatherless boy attain the responsibility and reliability that is needed to develop closer ties with other children.

- To help all the children in a fatherless family achieve increased understanding of each other's needs and more positive parent-children relationships.

Thus, the Big Brother agencies in the United States and Canada are providing experience for helping the single-parent family function as a "family form" in itself.

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MOSS: Some broader implications

I wish to comment on the process for family interviews in preplacement planning and postplacement service to children placed voluntarily in institutions as described by Sidney Z. Moss in *CHILDREN*, November-December 1968. ["Integration of the Family into the Child Placement Process."] His position can be heartily endorsed at a time when caseworkers still operate on the one-to-one interview with the mistaken idea they are protecting the troubled child from the harshness of placement realities.

Mr. Moss says the word "institution" could be replaced with "foster home." We could also substitute for the phrase "voluntary placement" the phrase "involuntary or court-ordered placement," the type of placement so well known to the public agency working in the area of protective services. The use of the family interview with participation by the child prior to and at the time of the court hearing and of the resulting foster home placement could accomplish the same kind of family mobilization Mr. Moss describes in relation to voluntary institutional placement. The fact of

custody should not stand in the way of our continuously reaching out to parents involuntarily deprived of their children.

The article outlines good practice in family-centered postplacement interviews. This concept of integrated service needs translation for the caseworker faced with postplacement service to parents, child, and foster parents when the child in the agency's custody has been placed in a foster home. Historically we have fragmented the postplacement process through separate interviews with parents, foster parents, and the child.

The purpose of postplacement service could be better served by joint interviews with all parties involved in the very complex parent-child-foster parent-caseworker constellation. Such interviews are sometimes arranged to assess progress, redefine goals, and plan for the future. If they were scheduled regularly and purposefully rather than at times of crisis with some vague idea of "getting everybody together," we might effectively and sensitively accomplish the reuniting of child and family. We could in this way come sooner to realistic decisions about permanent arrangements for the child away from his parents if this appeared to be the plan of choice.

We must acknowledge intricacies of family interviews for the caseworker who is accustomed to "taking Joe out for a coke." The worker could find the integrated family interview a three-ring circus unless he is provided inservice training and supervision specifically directed toward group interview techniques.

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John Doe
MARCH • APRIL 1969

children

CHILDREN UNDER THREE

some approaches
to stimulating
optimal development

Nutrition in Health Services



children

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

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The newest member of a family contemplates his admirers. Chances are that for him some basic elements in intellectual stimulation are being provided, for, as the lead article in this issue points out, being played with by older children and adults not only helps a baby distinguish between different people but also, through their feedback of delight, pride, or surprise at whatever he does, enhances the importance to him of his achievements and so stimulates further efforts.

children

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LOIS BARCLAY MURPHY

● Since the beginning of World War II, the U.S. gross national product (GNP)—the aggregate of its agricultural and industrial output—has steadily increased. Unfortunately, the Nation has not proportionately increased its resources for protecting its human products. Neglect of prenatal care, birth defects, nutritional needs, and appropriate infant care lies behind our poor standing among the nations in infant mortality rates—1: highly developed nations have reported rates lower than the United States.¹ It also underlies much of the distorted development of children as reflected in mental retardation, delinquency, and mental illness. This neglect has been paralleled by the country's failure to provide employment for the thousands of workers abandoned by employers as technology has superseded human labor on farms, in mines, and in factories.

As a result of such neglect of human needs, today large numbers of children throughout the Nation are unable to make use of the learning opportunities provided by the schools. Discouraged, depressed, undernourished parents become apathetic and so rear their children for passive tolerance of frustration rather than for active mastery of a skill. Too many children in lower socioeconomic groups do not learn to learn; their speech, concepts, experience, and drive to achieve are inadequate for learning. Their normal aggression is not directed into socially constructive channels, and they have little help in dealing with

CHILDREN

UNDER

THREE . . .

finding
ways to
stimulate
development

I. ISSUES IN RESEARCH

emotional problems, which arise more often among the disadvantaged than among other segments of the population.² In the past decade, however, many pressures—the space race, a personal concern about retardation on the part of persons in high office, and research reporting school failure among millions of poor children, white, black, and Mexican-American—have brought about efforts to do something about their faltering intellectual development.

The first response was legislation to provide some Federal aid to the schools, but this could do little to help the child who arrived at kindergarten or the first grade with an irreversible intellectual handicap. Then came Project Head Start to ready the preschool child for school and also some exhilarating experiments in the cognitive stimulation of preschool children, sometimes reinforced by candy rewards. But it was discovered that “Head Start was too late” and candy was not enough. Some children’s IQ’s did increase as they participated in these experiments, but their scores tended to lapse back again or even to get lower after they entered school. As this tendency became apparent, there came a push for cognitive stimulation of babies, based on the research efforts of learn-

ing theorists. Some of these theorists, however, were operating from their own conceptual islands, ignoring the forces of drive, motivation, affective response, constitutional factors, individual personality, and subculture values that could thwart or attenuate the effects of learning techniques and gastric rewards. Nevertheless, some cognitive stimulators even asserted that the prevention of delinquency, emotional disturbance, and a negative self-image could all be achieved through early cognitive stimulation.

Meantime, other forces were at work. The stultifying and distorting effects of sterile institutional life on children without families had led to the widespread avoidance of institutional care. Foster families were to provide the nearest equivalent to a natural family for the children who had no “real” mother or father, or no adequate parents. In some cases this goal was achieved. But in the large cities, the limited space in most families’ homes and the many parentless, neglected, or mistreated children defeated efforts to find foster homes for all who needed them; moreover, the stress experienced by families who attempted to bring up foster children in a crowded urban setting led in many instances to shifts from one home to another,³ which defeated the aim of a stable family life for these children. After a series of acceptances and rejections, many children became disturbed and alienated and as a result they had difficulties in school and the community.

The observations on which this article is based were made during work under two grants from the Public Health Service—MH10421 to the Children’s Hospital of the District of Columbia and 5 R12 MH9236-02 to the Menninger Foundation, Topeka, Kans.

In response to these problems, the pendulum has swung back to a revived interest in group care, at least in the form of supplementary care during the day. This interest has become more intense as a result of the view that mothers who passively receive public assistance might better go to work and let their children be cared for in adequate day-care centers. Because of the simultaneous concern about school failures, the thinking about day care has tended to focus on cognitive stimulation, as if this were the only need to be met.

Most of the discussion of cognitive stimulation has been oriented toward children from 3 to 5 years old, but in the past 5 years children under 3 have also begun to receive attention. Under the impression that "Head Start is too late," research workers have been exploring the effects of cognitive stimulation on babies.

An underlying error

One major error underlies many failures to provide for adequate development: the notion that "We have the answer." There was a time when the central concern of administrators of child-care programs was to prevent infection: they thought that if the children were kept clean they would grow well. At other times, "the" answer was thought to be good nutrition, or fresh air, or activity, or freedom. And now it is cognitive stimulation. But disappointments have followed each one-track attempt to follow "the" one important prescription, as Skeels,⁴ Spitz,⁵ and others have shown in studying clean, but sterile, institutions. We now know that institutionalized children who are merely kept clean and well fed lack most of the ingredients for healthy personality, social, and cognitive development: and that these lacks contribute to varying degrees and kinds of deficiency and distortion—mental retardation, social inadequacy, disorganized behavior, delinquency, failure to grow, and at worst marasmus and death.

In Israeli kibbutzim and in the best day-care centers in the United States, the multiple needs of the child are met: warm, mothering caretakers provide stimulation, space for activity, time for free play, response to the child's efforts, along with lots of fresh air and good food—and a chance to experience joy. It seems paradoxical that so many recent investigators are again following a single track—cognitive stimulation through specific teaching programs—and overlooking many other aspects of development, despite evidence that nutrition, activity, emotions,

and human relationships affect a child's learning.

Moreover, in many instances the idea of what learning is has been shaped by a narrow range of concepts such as vocabulary, memory, reasoning, and comprehension and by Piaget's insights regarding the child's development of time and space concepts and the conservation of objects. But the growth of a child's mind involves many cognitive functions (including complex sensory-motor and coping efforts) not measured in intelligence tests. These include, for example: differentiation between the familiar and the strange; the process of familiarization (visual and auditory examination, manual manipulation, and so forth); movement-in-space problems; combining objects; solving problems requiring manipulation use of tools, such as the door knob, screen hook, faucet knob; self-dressing—pulling off and putting on socks; finding or creating substitutes; and clarification of relationships and experience by rehearsing them in fantasy.

Ability to do such things develops in children who are growing up in an environment where they are exposed to a variety of objects, challenges, and opportunities to use their minds and bodies and can observe the everyday problem solving of their parents and brothers and sisters. As with all aspects of mental development, development of these skills needs the support of varied experience.

Criteria for evaluation

How then shall we formulate what is needed to foster good physical, emotional, social, and cognitive development? And what criteria should guide research for evaluating programs for children under 3?

Here I list seven basic areas to consider in evaluating proposals for early child care:

1. *Adequate nutrition*—proteins, vitamins, minerals, and other nutrients required for the physical development of the child. In many parts of the world, where infants receive insufficient protein and other nutrients, the mortality rates among children are high. A large proportion of those who manage to live are malnourished, vulnerable to infection, and retarded. Similar conditions are reported to exist among infants and small children in "hunger areas" of the United States.

2. *Ability to deal with the baby in distress.* How to handle the baby who has poor digestion, colic, diarrhea or constipation, or susceptibility to infection

is still inadequately understood by many child-care workers. That there are *emotional and mental consequences of distress in early infancy* is even less appreciated. Such babies need help with gastrointestinal and other aspects of basic functioning. Marked or prolonged infantile distress, or both, can contribute to anxiety, hostile reactions, withdrawal, and disturbances of perception and cognition.

3. *Stimulation designed to meet the infants' needs, tolerance level, and capacity for enjoyment* at different stages of sensory-motor development, emotional response, and resources for self-management. What is too much for one infant may not be enough for another. The kind and amount of stimulation provided each infant have to be based on intelligent observations made by his mother or mother-surrogate. Sensitive mothers report such observations as: "He likes bright colors"; "He minds soft noises more than loud ones"; "His bath has to be just the right temperature"; or "He can sleep in the midst of noise." One baby likes to be jounced vigorously while another likes gentle, rhythmic rocking. Visual, auditory, kinesthetic, rhythmic stimulation are each important. The proper amount of stimulation implies both protection from excessive or overwhelming stimuli, which the baby cannot manage or which disrupt his functioning, and provision of enough stimulation of satisfying kinds to encourage response.

4. *Talking to the baby.* This provides important support for the baby's own vocalizing efforts that are a precursor of language.

5. *Opportunities for exercise of emerging sensory-motor functions*, through handling toys and other objects. Such activities as touching, feeling, banging, throwing, or combining teach the baby the qualities of things and also help him develop awareness of himself, the different parts of his body and what he can do. Being played with by older children and adults helps him become accustomed to different people, to distinguish his mother or caretaker from others, and to develop flexibility in responding to and interacting with others. In addition, the adult's or older child's delight, pride, and surprise at the baby's reaction provide an important feedback to the infant and, by enhancing the importance to him of his own achievements, stimulate further efforts on his part.

6. *Encouragement of the baby's efforts* to make himself comfortable, amuse himself, feed himself, and master new skills. Such efforts can help the baby

develop independence and an ability to cope with problems.

7. *Continuity in a few basic, warm relationships*, as with a mother, father, brothers, sisters, and other relatives. Such continuity contributes to the development of a stable core of self, a sense of being valued, a capacity for dependable relationships, a sense of trust, and identification with motherly and fatherly adults.

Interrelated factors

The child's emotional and affective development seems to go hand in hand with his social responsiveness. And, according to studies made among children of higher socioeconomic status, relationships also exist between social behavior and the level of language development.⁶ Both superior language development and superior social and emotional development have been found to reflect the quality of family interaction. Some studies of family life that describe conversation between parents and children at meal-times suggest that the higher level of verbal exchange found in middle- and upper-middle-class families is an integral part of the social atmosphere in families that enjoy their children and communicate with them regularly. In such families, the social and emotional interaction itself provides cognitive stimulation and contributes substantially to language development as well as to the development of perception and other cognitive faculties. Our studies at the Menninger Foundation found positive correlations between the mother's talking to the baby and the baby's vocalization, as well as between the baby's vocalization and his later IQ.⁷ These findings probably reflect the mother's affective response to communication initiated by the baby as well as the baby's response to the mother.

It is astonishing that in current efforts to stimulate the intellectual development of deprived children, so little detailed analysis has been made of the day-to-day communication between parents and children in well-functioning families as compared with parent-child communication in depressed families of any specific socioeconomic, racial, or other subcultural group. Aspects of cognition stimulated by such communication also need to be studied. There is no lack of research methods. For example, Barker and Wright have provided detailed, moment-by-moment records of a child's life through one day;⁸ Escalona and Leitch have provided even more detailed records on infants;⁹ Leon Yarrow and his team have re-

corded in detail a baby's response to environment.¹⁰

Much recent research on cognitive development as such and ways of stimulating it in young children has been carried out without a sufficiently broad orientation to the total context of mental development. The procedure of some investigators might be compared to that of a man who in order to fly to Samoa equipped himself with the best airplane and took off with a plan to fly southwest without studying all the relevant factors such as headwinds, tailwinds, climatic variations at different longitudes and latitudes, or visual landmarks. The need is for a full analysis of the *total* developmental context in which learning takes place, both in formal stimulation situations (which always include factors not mentioned in the records) and within families of various socioeconomic backgrounds.

Some questions

A host of questions cry for answers: What was the atmosphere in the learning situation in which marked success occurred as compared with the situation that produced only limited success? Did the first situation involve a day-care teacher who enjoyed children and made their daily experiences happier, more fun, and thereby, perhaps, more stimulating? Is it possible that some caretakers who take a personal interest in each child evoke in the child a deeper identification with the teacher and a deeper investment in the learning process? Do some children through identification with the teacher or through other as yet unrecognized processes acquire a "drive to learn" that furthers their progress?

The lack of curiosity and drive to explore, of capacity for organization, planning, and creativity, and of the resourcefulness that these traits utilize and develop has been characteristic of many children in Head Start programs. A child needs such tendencies and capacities to clarify potential uses of his cognitive resources and to find new satisfactions in putting them to work in interesting ways. But the roots of such cognitive activity have not been adequately studied. Could it be that the relative emptiness and monotony of the environment in economically deprived homes automatically prevent the child from making comparisons, finding interesting similarities and differences, organizing experiences in exciting new ways, or trying to make an increasingly detailed and expanding "cognitive map," as children in middle-class homes must do to cope with the variety of experiences in their richer environment?

There is an urgent need to compare the effects of different experimental methods with the effects of the methods used in good "traditional" nursery schools as described in the literature.^{11,12} Such a comparison, ideally, would involve a careful, comprehensive analysis of the cognitive aspects of all the activities of children in nursery school. An analysis of this kind would require fresh study of the complex processes through which the child integrates and reconstructs his observations of objects, parts of the environment, and adult roles and rehearses for future activity. These mental processes and others are involved in activities typical of good nursery school programs—for example, block construction, puzzle solving, painting and drawing, storytelling and description of discoveries by the child, and group imaginative play. Cognitive aspects of social experience should also be studied. Such processes as learning to take turns, to work together on joint tasks, to explain feelings of anger instead of beating up or biting the offender, to plan a joint block-building project all involve cognitive efforts of varying degrees of complexity of understanding, verbal skill, sequential ideation, organization of objects and people, and useful fantasy.

Complex preschool activities like these have significance for many aspects of development in the young child, among others: (a) putting cognitive skills to work in activity the child cares a great deal about; (b) developing skills, insight, and values important as foundations for socialization; and (c) enhancing the sense of autonomy, the capacity to cope with varied life situations, and the drive to continue in the social use of cognitive resources. The child becomes self-propelling in his cognitive, affective, and social use of the environment. These beginnings imply possible next steps in research, which are foreshadowed in the discriminating reports of Herbert Zimiles.¹³

Individual differences

Another point needs emphasis. Most results of experiments in cognitive stimulation have been reported in terms of averages or means on the assumption that the only adequate measurement of change is a summary of the change in a group as a whole. Such a statistical approach has been sharply criticized by some of the world's most outstanding statisticians. One of these, C. R. Rao,¹⁴ urges that subgroups be looked at separately to avoid the confusion of results when two contrary tendencies are

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represented in the same group. For instance, when we find that in a given group the level of cognitive functioning has decreased in some children and dramatically increased in others, we need to consider the factors behind these opposite responses. What was going on in the lives of those children whose level of functioning has decreased? Did the child become ill? Was there some severe trauma at home? Was the child disturbed by separation from home and mother? Did the child have special needs that were not met? Similarly we need to learn more about the children who made the greatest progress. Were these the children whom the teacher particularly appreciated or enjoyed, tuned in with, or felt she understood?

In other words, we need to consider the individual physiological, social, and emotional context of both negative and positive changes in cognitive development. At the same time we need more study of the differences in individual children's responses to whatever is offered or withheld—differences in what evokes interest and drive as contrasted with withdrawal, in vulnerability to deprivation, separation, and strangeness, and in capacity to cope with the tresses of life.

Research on the early years, then, must ask: What physical, emotional, and cognitive support does each child need for optimal all-round development?

A project that will attempt to answer these questions is just getting underway at the Children's Hospital of the District of Columbia. It is aimed at demonstrating the advantages for infants and young children of group care in settings that emphasize warm relationships and careful attention to the individual needs of each child. Still in a pilot stage, the project is designed on the theory that only comprehensive support for the infant's physical, mental, and personality development will be adequate.

The project will attempt to provide the baby with

a foundation for developing a strong healthy body and emotional stability, a trusting but independent outlook, curiosity and a drive to learn, responsiveness to and considerateness of other people, and a capacity for participating in social endeavors. In one group each child's mother or mother substitute will receive help closely related to the needs of her child in the belief that if the gains from a good beginning are to be maintained, the child's mother must be helped to understand his needs and to use the community resources to strengthen her family life. She will also receive training and education that will develop her own potentialities, confidence, and determination to further support her children's development. The program is bound to be expensive, but its potentialities are great, especially since attention to each child's individual maturational tempo, areas of sensitivity, and range of interest is rarely included in experimental programs.

Varied approaches

Many if not most experiments in cognitive stimulation work with a selected group: one, for example, excludes infants with birth defects or evidence of retardation, and those whose mothers suffered complications in childbirth or have been mentally ill—problems most frequent in low socioeconomic groups. The result is that only the "cream" of the poor are the subjects of the experiment. Another experiment selects children whose mothers agree in one interview to cooperate with the study, thus omitting the children of mothers who are shy, suspicious, or uncooperative. Other experiments only take children whose families give evidence of stability of residence or whose homes are free from crowding or other disturbing conditions.

These and other criteria for sample selection are established to eliminate handicaps to the effects of the experimental work. They do this, but at the same time they exclude the opportunity to find out whether restitutive efforts can help the development of those children most likely to add to the aggregate of learning failures and behavior problems. Therefore, such experiments with poor children must be considered as only first steps in the prevention of distorted development, steps that may lead further to experiments with children in "hard-core" families—the distrustful, unstable segment of the poor.

The reports of some current experiments presented in this issue of *CHILDREN* illustrate differences in approach as well as in strengths and limitations.

Francis Palmer's study in Harlem throws light on the relative contributions of formalized procedure and the freedom of adult-child interaction that rewards the child's initiative. The study documents the importance for the very young child of the warm one-to-one relationship with the educating adult.

In the tutoring approach described by Earl Schaefer, the disadvantaged child is introduced to a wealth of materials and activities comparable to that available to a middle-class child. He reports that at 36 months the mean IQ of the children in his experimental group was close to "high average," and the lowest IQ was 89; therefore, we can assume that some IQ's came close to 130 (selected for "adequate home conditions"). The difference of 17 points between the experimental group and the untutored group is almost as great as the difference found in an earlier study between the average IQ of children of unskilled workers and the children of professional and business workers. I commented in 1937 that this difference was comparable to the increase in IQ found in an Iowa study among children whose environment had been improved. This old finding is relevant to Schaefer's results.

If we compare Palmer's and Schaefer's work with that of other recent experimenters, we have to note the influence on the results not only of the enrichment program but also of the tutor's positive relationships with the child and his family. We now need a careful description of what positive relationships involve, and a careful theoretical formulation of the factors, such as motivation, drive, and expectancy, evoked by positive relationships. Far more than strictly cognitive stimulation is included.

Ira Gordon's experiment in teaching indigent mothers how to stimulate their young children is directly concerned with the mother's sense of personal worth and competence.

Halbert Robinson's description of a center which attempts to approximate the richness of family life implies the importance of ongoing varied interactions. This center offers disadvantaged children not only the stimulus of an enriched environment with warm, adult attention, but also pacemaking contacts with children from stimulating homes. As an innovative project, this should result in new hypotheses

and insight into the contribution of rich social interaction to cognitive, social, and emotional growth.

The first aim of the project at the Yale Child Study Center, described by Sally Provence, is to help the parents develop their capacity for parenthood so that the development of their children is enhanced. The theory is that, if parents can begin to identify with healthy attitudes and to imitate constructive child-rearing methods, they will develop into better parents and their relationships with their children will contribute to better child development.

We can expect that new knowledge will emerge from each of these experiments in proportion to the investigator's receptiveness to unanticipated data and careful scrutiny of the processes that contribute to expected results.

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CHILDREN

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II. SOME CURRENT EXPERIMENTS

A THREE-PRONGED PROJECT

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● Improving the chances for adequate development of children at risk of impaired development due to a way of life imposed on their parents by poverty, discrimination, and lack of opportunity is one of society's most urgent tasks. Stimulated by this need, the Yale Child Study Center, Yale University School of Medicine, with support from the Children's Bureau, has instituted a research project based on two major assumptions: (1) that services to enhance the child's development should be available to him as early in his life as pos-

sible; (2) that services to parents to support their development as adults who can nurture their children are an important aspect of making children's services effective. Lasting benefits to the child are unlikely to occur without parental support.

Following a pilot study to test methods and allow for formation of a smoothly functioning team of research and service workers, selection of subjects for the study proper began in the fall of 1968. It is a longitudinal study that eventually will include three groups of children from low-income families, to be studied from early infancy to 7 years of age: (1) a group living with both of their own parents; (2) a group living in foster families; (3) a group living in a specially devised residence for congregate care.

Each group will consist of about 25 children and will be paralleled by a control group of children in the same type of living arrangement. Most of the children living with their own parents will be selected through the Women's Clinic of the Yale-New Haven Medical Center from families expecting their first child. Those living in foster families will be children who are placed away from home in infancy by the local welfare department in the course of its normal child welfare program. Those living in the residential setting will be children needing care away from home from infancy for whom the welfare department cannot find adoptive or permanent foster families. At this writing (January 1969), the project

has selected only the group of children living with their own parents and is already providing them with the full range of health, educational, and social services that will eventually also be provided to the children in the other experimental groups.

The project's major objectives are:

1. To provide advice, support, and casework treatment to parents and foster parents to help them develop their capacity for parenthood.

2. To design a program of group residential care for infants and children up to 7 years of age geared to the needs of children and to compare the development of the children in the program with children in other institutions. Because of the difficulty of finding a suitable house for this purpose, this phase of the project has been temporarily deferred. The plan, however, is to insure that there is sufficient staff to provide each child with a person with whom he can develop a close relationship. In addition, the environment will include a variety of planned experiences with activities and materials that will support general development and learning.

3. To design a program of educationally oriented day care for the three groups of intensively studied infants and young children that might be used as a model for others. The day-care center now in operation was opened in the fall of 1967 as the setting of the pilot study. Infants are brought to the center for 2 or 3 hours a day—or for full day care if their mothers are working. In the center, most of the interaction with the young infant occurs while his bodily needs are met. Later a balanced program of stimulation and respite from stimulation is provided, determined by the infant's developmental level and his individual temperament. As the children grow older, the center's program will be revised appropriately.

4. To compare the development of the three groups of children from infancy through 7 years of age in various dimensions—areas of functioning, personality development, and behavior—in relation to the three types of environment.

5. To derive from the research findings guidelines for providing effective services to children and families that will be feasible for widespread application.

6. To study in depth individual children in the three types of environment with the view of increasing understanding of the complex interaction

between the child's unique endowment, his particular environment, and his particular phase of development.

7. To devise a training program for people who will provide services to children and help to parents in developing their parental capacities—child-care workers in day-care and residential settings and paraprofessional workers to assist parents—and to enrich the professional training of social workers, nurses, and teachers.

The children will be studied in the three types of living situations as well as in the day-care center, in a pediatric clinic, and in individual testing and play sessions. The multidisciplinary research team consists of investigators from the fields of medicine (pediatrics and psychiatry), child development, psychoanalysis, social work, early childhood education, psychology, and nursing. Because the research project is service centered, the investigators include both participant- and nonparticipant-observers.

The participant-observers render services in "family teams" and so have direct contact with the children and their parents. The social worker and the nurse visit the families regularly, providing supportive services to the parents. The pediatrician gives the children medical attention in the clinic and in home visits. The teacher and the child-care worker work with the children in the day-care center, the teacher providing and supervising learning experiences and the child-care worker assisting her in providing these learning experiences and in meeting the children's other needs.

All these family team members while rendering their services also use their special skills as observers to gather data about the child and the family important to the investigation. Nonparticipant-observers of the same professions provide another set of observations which tend to minimize bias or support consensus. Most of the observations of the nonparticipant-observers take place in the center.

The research advantages of a service-centered approach derive chiefly from the fact that when parents receive response to their own and their children's needs (in the form of advice, emotional support, and alleviation of suffering) they tend steadily, if slowly, to develop trust in the members of the research team. This gives the team members access to information about the parents and their children that otherwise would be unobtainable. Another advantage is that the data on the children are collected in set-

things that are not artificially controlled—their own homes, a day-care center, the pediatric clinic. As time goes on, the various crises that occur in families will also provide important data.

The growth and change in the child and family over a period of 7 years will provide an excellent opportunity for approaching some of the remarkably complex issues in the field of child welfare and, we hope, will yield knowledge that will help to improve the lives of children at risk of impaired development because of adverse conditions in society.

LEARNING AT TWO

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That the young child needs stimulation to develop intellectually is unquestionable.

However, exposure to complex stimulation may not alone be conducive to optimal intellectual performance. Some support for this hypothesis exists in the findings thus far of research being conducted at the Harlem Research Center of The City University of New York as part of a study supported by the National Institute of Child Health and Human Development (HD02253).

The longitudinal study involves 310 Negro males born in Manhattan hospitals between August and December of 1964 and takes into account socioeconomic status, type of training received, and the age when training was begun.

The experimental group includes 120 boys who began training at age 2 and 120 who began at age 3. The 70 boys who serve as controls attend the

center for assessment purposes only. All the children will be followed by the research project until they complete the first grade of school.

The 240 children in the experiment attended the center for two 1-hour sessions each week over an 8-month period. In these sessions the children interacted, uninterrupted, with an instructor on a one-to-one basis. Their instructors changed every sixth session, and only rarely did a child have the same instructor more than once during the 8 months. The children were assigned to one of two training groups, concept training or discovery. Children in the concept training group were systematically taught to understand concepts, beginning with such simple ones as top of, open, wet, smooth, and progressing to more complex ones such as far, many, same, different, and so forth. The children in the discovery group were provided with the same play materials and instructors as the children in the concept training group, but the instructors did not at any time label the concepts for the child or initiate a conversation with him. They played with the child, letting the child take the lead in the interaction. A separate study found much more verbalization by concept training instructors than by discovery instructors, thus confirming these differences in method.

So far we can report the following encouraging results regarding the children who began training at the age of 2.

After 8 months of training, both experimental groups performed better than those in the control group on 14 of 16 measures, nine of these differences being statistically significant. The experimental groups were superior on such diverse tasks as the Stanford-Binet Intelligence Test, language comprehension and use, perceptual discrimination, motor behavior, delayed reaction, and persistence at a boring task. More important, children of lower socioeconomic background in the experimental group outperformed the middle-class children in the control group on 14 of the measures, on four of which the differences were statistically significant.

Furthermore, when the children in the experimental groups were retested a year later, they maintained their superiority on all but four of the assessment measures. Thus, not only did the treatment conditions have significant effects on the boys' intellectual development at this early age, but the effects were durable for at least 1 year.

However, we were surprised to find that when the two experimental groups were compared, the children exposed to the meticulously developed concept

training curriculum performed significantly better than the children in the discovery group on four measures only: (1) the concept familiarity index, which is highly loaded with items taught in the curriculum; (2) motor performance; (3) ability to follow instructions in sequence; and (4) simple form discrimination. On all other measures, the children in the discovery group did as well or better. Thus it appears that the concept training did not generalize to other dimensions of behavior any more than did the discovery condition.

We interpret these findings as follows: (a) The 2-year-old is highly capable of learning a great deal with only 2 hours per week of instruction; but (b) what he is taught is not so important as the conditions under which he is taught, specifically the nature of the adult-child relationship.

Among people who choose to work with children, it is rare to find a person who does not develop an affective bond with the child with whom he is working, given the opportunity for uninterrupted interaction. In both the concept training and discovery groups, this condition existed. In the concept training group the child's response to the situation was usually specific to the training materials, and he was guided by the instructor. In the discovery group, the child's response was perhaps less frequently specific to the materials and the requirements of the instruc-

tor, but he was rewarded by the instructor's voice, gesture, or physical contact when he initiated a response. Thus, both conditions provided the child with an opportunity to respond and be rewarded in a situation that allowed for a strong affectional bond, and increasingly complex stimuli requiring increasingly complex responses. As the program progressed, most children found it possible to organize the stimulation they received and to respond to the instructor with increasing ease and effectiveness.

We believe that the superior performance of both experimental groups was the result of one or more of the following elements: (1) the regularity of exposure to a structured learning condition; (2) the affective relationship between instructor and child; (3) the uninterrupted nature of the instructor-child interaction; (4) the increasing realization by the child that he could respond to stimulation and be rewarded for his response.

Exposure to response-facilitating conditions may at this age be the essential ingredient for the child's developing a more sophisticated aspect of information processing than he would under exposure to an ordinary play situation or traditional nursery school activities. The difference is like the difference between reading a detective story for relaxation and reading a textbook for information the reader knows he must organize and be prepared to respond with upon request. One situation is self-satisfying; the reader seeks nothing from the information other than pleasure. In the other situation, the reader must organize the information he gains so that he may do something with it later. This requires a high level of intellective functioning—an ability developed by some people earlier than others and by some to a higher degree than others. While it is not presently fashionable to conceive of intelligence as a unitary factor, this organizing ability surely is important to many aspects of what we call intelligence.

The affective bond between instructor and child may be a motivating force for the child, a force that is most effective in the one-to-one interpersonal relationship and that has ample opportunity to develop in the uninterrupted 45-minute training session. In both kinds of training sessions—concept and discovery—the child had the complete attention of the instructor most of the time, without external distraction. It is doubtful whether many young children, even in the best homes, are provided such an opportunity on a regular and planned basis by their mothers, busy as they are with household chores and other children.

Playing with a piece of a Montessori transportation puzzle, this happy youngster at the Harlem Research Center is learning to discriminate forms in a concept training session.



We conclude that the concept curriculum so laboriously developed may be no better than other curricula planned with equal care. A curriculum stressing language and vocabulary development might serve as well. The structure under which the curriculum is offered should, however, create an environment where learning by the child can best occur. In day-care centers and nursery schools, such an environment is less likely to exist than in a one-to-one teaching situation, because of the many distractions that may arise for instructor and child.

We do not know the effects these different types of curricula would achieve were they embedded in traditional day-care or nursery school programs. Clearly such programs provide an opportunity for more comprehensive attention to the child's intellectual needs and should be systematically evaluated under controlled conditions.

creases the mother's competence and sense of personal worth. A third objective is to find out more about the home life of children in the indigent population in the area.

The program consists of providing instruction to the mother by the parent educator in a sequence of stimulation exercises. The stimulation procedure involves a systematic series of sensory-motor, tactile, and verbal experiences developed after a review of research theory and findings on cognitive and affective development in the earliest years.¹ Instruction is given about once a week in the home. The mother is instructed not only in the mechanics of the exercises, but also in developing an attitude toward them as play to be enjoyed by both herself and her child. The parent educator presents the toys and play materials to the child in a way to help the mother learn by imitation, involving the mother in each task with the child.

The parent educators will continue to work with individual children and their mothers in their homes until the children are 2 years old. At that age, the children will be taken by their mothers twice a week to "backyard centers," set up in the homes of selected participating families, for special instruction and activities. The parent educators will serve as center directors, and the mothers who supply the space for backyard centers will serve as their assistants.

The first phase of the study began in the summer of 1966 by selecting participants from mothers and their newborn infants in the J. Hillis Miller Health Center Training Hospital, University of Florida. Criteria for selection, in addition to the economic code of "indigent" on the hospital admission form, were: single birth; no breech or Caesarean delivery; no birth complications involving either mother or infant; no evidence of mental retardation in the child; and no evidence of mental illness on the part of the mother. On selection, the mothers and their infants were assigned to either the experimental or control group at random. As of February 1968, this first phase included 95 mothers and infants in the experimental group and 80 in the control group.

Fifteen parent educators—12 Negro women and three white women, roughly approximating the proportion of Negro and white deliveries at the health center—were selected in August 1966. The original criteria for selection were high school graduation; unemployed or low-level employment; and some experience with infants. Eleven of the original group remain in the project as of November 1968.

A second phase of the project was begun in July

STIMULATION VIA PARENT EDUCATION

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For the past 2½ years, the University of Florida has been experimenting with the use of women from disadvantaged neighborhoods to teach indigent mothers of infants and young children how to stimulate their children's development. The project, which receives support from the Children's Bureau and the National Institute of Mental Health, has two related objectives: To find out whether the use of such parent educators (1) enhances the development of the children and (2) in-

1967 with the addition of two new experimental groups and one control group, involving a total of 120 new families—80 in the experimental group and 40 in the control group. This phase was designed to test whether the particular series of activities or another pattern with greater emphasis on locomotor development and with equal amount of time spent in the home instructing the mother might contribute more to child development. Six new half-time parent educators were added at that time.

The parent educators' training has taken place in two phases: (1) an intensive 5-week course given before the parent educators began home visits; and (2) a continuing inservice program once a week. The intensive course dealt with the stimulation tasks to be taught the children, interview techniques learned through role playing, observation procedures, and recordkeeping, as well as general information about child development. The inservice program continues this type of training, but also provides the parent educators with opportunities to discuss problems, learn about community services, and plan new learning tasks. During their training, the parent educators have helped develop the testing instruments and have supplied ideas about future directions for the program.

The program has not been in progress long enough to test how lasting its effects will be. But the data on 146 children in the first group still with the project at one year of age indicate that the program enhances the development of children in their first year. The children were tested on the Griffiths Mental Development Scale as close to their first birthday as possible. The scores of 85 children in the experimental group were compared with those of 61 children in the control group. The Griffiths Mental Development Scale yields not only a general intelligence quotient (IQ) but also subquotients in the areas of hearing and speech, eye and hand coordination, personal-social relationships, performance (in handling objects), and locomotor development. The results of the tests showed significant differences in favor of the experimental children in regard to general IQ and hearing and speech, eye and hand coordination, and personal-social relationships. Most of these differences seemed to be due to gains made by girls in the experimental group.²

The two groups of children were also tested for their performance of the tasks in the project's series. Our notion was that their experiences during the first year should result in a higher percentage of experimentals than controls passing not only the tasks they

had been taught but also tasks they had not yet been taught; that is, that the learning of taught tasks should have enhanced the children's ability to figure things out for themselves. Each child was tested on a mixture of taught and untaught tasks. The experimental children succeeded more frequently than the controls not only on the great majority of the tasks taught, but also on more of the untaught tasks.³

The second objective of the project—to increase the mother's sense of confidence and personal worth—is still being tested.

Two scales for doing this were developed during the first year. The How I See Myself (HISM) modifies one created for elementary and high school students;⁴ the Social Reaction Inventory (SRI) modifies the Rotter I-E Scale,⁵ which measures a person's sense of being or not being in control of his own life. The mothers in the second group were tested on these scales when they entered the project. The results of their HISM tests, when compared with the scores of lower class, high school girls, showed that the mothers were lower in self-esteem, sense of interpersonal adequacy, regard for their own physical appearance, and sense of autonomy, and were more negative in their attitudes toward teachers and school. Preliminary data from HISM tests taken 9 months later indicate that the mothers have improved in all these areas except autonomy. The SRI test results indicate that the mothers more than any of the groups that have been measured by Rotter, tend to feel that their lives are externally controlled.

In regard to the project's third objective—to increase our knowledge of the home life of the infants in this population—a great deal of information has been obtained from the weekly observations made by the parent educators. However, this has not as yet been analyzed in detail.

One member of the research team studied 20 families in the control group for patterns of maternal verbalization, reward, and punishment,⁶ visiting them once a month for a year. She found a steady increase in the frequency of punishment of the children between the ages of 3 and 12 months. However, she saw little physical punishment of the children. The major punishment techniques were removal from the situation and threats. The mothers' major rewarding behavior was smiling. There were very few verbal rewards. When such data are analyzed for the total population of the study, such trends and many others will be related to child performance.

We feel that thus far the experience of this project indicates that (1) a parent education program using

nonprofessionals and serving mothers living in difficult urban and rural conditions can be maintained and that (2) this type of program does seem to enhance the development of infants whose mothers are reached in their homes. As the program continues, we will learn better what effects such a program has on the mothers and whether the effects on the infants are cumulative or lost over time.

¹ Gordon, I. J.; Lally, J. R.: Intellectual stimulation for infants and toddlers. Institute for Development of Human Resources, University of Florida, Gainesville, Fla. 1967.

² Lally, J. R.: A study of the scores of trained and untrained twelve-month-old environmentally deprived infants on the "Griffiths Mental Development Scale." Unpublished doctoral dissertation, University of Florida, Gainesville, Fla. 1968.

³ Gordon, I. J.: Early child stimulation through parent education: a progress report to the Children's Bureau, Department of Health, Education, and Welfare (Grant No. R-306). University of Florida, Gainesville, Fla. 1968.

⁴ ———: A test manual for the How I See Myself Scale. Florida Educational Research and Development Council, University of Florida, Gainesville, Fla. 1968.


⁵ Rotter, J.: Generalized expectancies for internal versus external control of reinforcement. *Psychological Monographs*, vol. 80, no. 1, 1966.

⁶ Bradshaw, C. E.: Relationship between maternal behavior and infant performance in environmentally disadvantaged homes. Unpublished doctoral dissertation, University of Florida, Gainesville, Fla. 1968.

A HOME TUTORING PROGRAM

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 A program of home tutoring was begun in September 1965 in Washington, D.C., by the National Institute of Mental Health to stimulate the intellectual development of very young chil-

dren of lower socioeconomic status. Information on family environment and maternal behavior was also collected through interviews and from observations during tutoring sessions.

An experimental group of 31 children under 2 years of age and a control group of 33 children of the same age were selected from door-to-door surveys of two lower socioeconomic neighborhoods. All the children were Negro males. Although children for the experimental and control groups were chosen from different neighborhoods, children from the two neighborhoods have comparable readiness scores at school entrance. Children were included in the experimental or control group only if their families agreed to participate in the study and met two of three criteria—family income under \$5,000, mother's education under 12 years of schooling, and mother's occupation, if any, either unskilled or semiskilled—and if their homes were not judged unsuitable for a tutoring situation. Comparisons between the groups revealed only small differences, many of which favored the control group, on family variables that might be expected to influence the child's intellectual development.

College graduates who had some experience with young children and some knowledge of the inner city were recruited as tutors. They received a brief period of training through lectures, observations of children in their homes and in child-care institutions, and a pilot, supervised tutoring experience. Throughout the project, there was continued supervision of tutoring, informal communication among staff members, and staff conferences on child care and educational methods. Two tutors alternated weekly in visiting each child in the experiment for an hour a day, 5 days a week, beginning when the child reached 15 months of age and continuing through 36 months of age.

The educational program was designed to develop positive relationships with the child and his family, and to provide verbal stimulation and varied and increasingly complex experiences. Some of the activities and materials included were walks and trips to the grocery store, drug store, fire station, zoo, library, and museum; holiday and birthday parties; picture books, storybooks, and scrapbooks; songs, nursery rhymes, and records; physical activities and games; puzzles, blocks, and various kinds of toys; and finger painting, drawing, and crafts. The educational program was developed from the experiences of the tutors and from reading, informal communication, and staff conferences. Participation of the mother and other family members in the activities was encour-



A tutor from the National Institute of Mental Health encourages her young pupil's interest in picture books.

aged but not required. In about one third of the families, the mothers or other family members showed a great deal of interest in participating in the activities; in about a third, they showed moderate interest; and in a third, little interest.

Psychologists administered intelligence tests to the children in both experimental and control groups at ages 14, 21, 27, and 36 months and also rated the children's test behavior. Tutors provided information on the home environment and experiences, the social and emotional behavior, and language development of the children in the experimental group and on their mothers' behavior toward them. The two tutors who visited a child on alternate weeks reported on him independently.

Mean IQ scores were computed from the Bayley Infant Mental Test and the Stanford-Binet Intelligence Test for the 28 experimental and 30 control children who stayed with the project to completion. The interpretation of the mean IQ scores must be guided by the facts that infant mental tests measure different functions at different ages and that early mental test scores have low correlations with mental test scores at later ages. Several studies have found

that low socioeconomic groups do not show low mental test scores prior to 18 months of age.

Mean IQ scores of both groups in this study were above the norms at the 14-month test (experimental mean IQ—105, control—108), which includes many sensory-motor items. On the 21-month test, which includes more verbal and cognitive items, both groups were below norms (experimental mean—97, control—90), but the experimental group mean IQ increased at 27 months (experimental mean—101, control—90) and again at 36 months (experimental mean—106, control—89) while the control group mean IQ remained low. These test results suggest that the children's experience in their first 15 months might have adversely influenced their early mental development, but that the home tutoring programs stimulated a more rapid rate of mental development later.

However, a year after the intensive home tutoring was terminated the intelligence scores of the children had dropped significantly, indicating that young children need not only early but also *continuing* stimulation for optimal intellectual growth.

The distribution of IQ scores for the experimental and control groups differed greatly, the lowest IQ of an experimental infant at 36 months—89—being equal to the mean IQ for the control group. Highly significant differences between groups were also found at 36 months on the Johns Hopkins Perceptual Test, the Peabody Picture Vocabulary Test, and on ratings of task-oriented behavior. The hypothesis that additional intellectual stimulation would produce higher intelligence test scores was confirmed by these results. In addition, informal observations of changes in both the child's and the mother's behavior and interests suggested that the home tutoring had many other effects that are less easily measured.

Analyses of the extensive data collected on the experimental groups at 36 months revealed significant correlations between methods of child care and the child's behavior and mental test scores. Three clusters of interrelated variables were isolated from the tutors' observations and labeled "child neglect," "maternal hostile uninvolvedness," and "child hostile maladjustment." In addition, clusters of child task-oriented behavior and mental test scores were isolated from the testing materials.

Child neglect correlated highly with maternal hostile uninvolvedness. Both child neglect and maternal hostile uninvolvedness correlated significantly with hostile maladjustment of the child. The tutors' observations of child neglect, of maternal hostile un-

involvement, and of child hostile maladjustment correlated significantly with the mental testers' independent blind ratings of low task-oriented behavior and low mental test scores on the part of the child, and these clusters also correlated highly with one another.

These data suggest that the quality of early maternal care has significant effect upon a child's adjustment, task-oriented behavior, and mental test scores at 36 months. If these findings can be replicated, they have major significance for future programs of prevention of social, emotional, and cognitive deficits in children. Their credibility is increased by related findings that supplementary tutoring and the adequacy of maternal care bear similar relationships to the child's adjustment and mental test scores at 36 months.

Although the subjects of this study were inner-city Negro children of low socioeconomic background, similar results would probably be found among children in other low socioeconomic groups. In fact, variations in maternal care that are related to variations in the child's social, emotional, and intellectual development might be found in all social groups.

A big boy and a little boy find each other mutually interesting at the Frank Porter Graham Child Development Center where children of different ages have a chance to play together as they usually do in normal families.



FROM INFANCY THROUGH SCHOOL

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The Frank Porter Graham Child Development Center of the University of North Carolina at Chapel Hill functions as a complex, long-range research project with support from a number of sources, including the Children's Bureau. It seeks (1) to discover a recipe for an optimum environment for a group of infants and children who vary in socioeconomic status, race, and sex; (2) to learn how to support parents' efforts by developing a comprehensive and easily available package of services for children, including full day care, complete health care, and education; (3) to discover what difference such a program will make in the long-range functioning and stability of the families and the development of children. The center provides a laboratory for professional persons from the many disciplines concerned with the family, with child development, and with the training of students who will work with families and children.

The present center, which began pilot operations in the fall of 1966, is the precursor of a much larger enterprise that will encompass both a day-care facility for more than 200 infants and young children and an elementary school for these children as they grow older and others who are being followed in the community. Children are usually admitted to the center as infants, some under 1 month of age, although the initial groups have included some 2-year-olds.

The general day care of all 31 children is at present centered in two cottage units, each of which has 15 or 16 children, mixed in age, and four child-care workers. In mid-January 1967, the oldest child was

4½ years and the youngest, 6 months. The children come from families representing the spread of socioeconomic background from upper middle class to disadvantaged. Half are boys; half, girls. Half are Negro; half, white.

The cottages are specially designed units in which the children eat, nap, play, and engage in individual and group activities, both planned and free. The equipment includes the items needed for basic care and in addition the toys, books, play equipment, musical instruments, and art supplies that characterize a good nursery school. The staff ensures that all children receive abundant attention and stimulation, are encouraged in independent and achievement-oriented behavior, and find warmth and support.

Infants and toddlers receive their educational training in the cottage units while the older children attend a preschool education facility for part of the day. The educational program encompasses language development, computational skills, perceptual and motor skills, art, music, reading, science, and a second language (French). The aim of this aspect of the project is to work toward the establishment of a sensible, coordinated, carefully evaluated curriculum that will eventually span the entire period from shortly after birth through elementary school. The preschool program has thus far received primary attention, but eventually it will be integrated with the elementary school through a continuous curriculum.

A unique feature of the center is its acceptance of children even when they are ill. Staff pediatricians, dentists, and nurses provide regular health surveillance and special care in case of illness. The full range of preventive health services and emergency care has been carried into the homes.

The rationale of the project encompasses several ideas to be tested: (1) That the best time to intervene into the cycle of deprivation and inadequacy is the period of infancy and very early childhood; (2) that if early experiences are continuous with later ones through the school's encouragement of the same

skills and abilities cultivated earlier, the gains made through the preschool program will not be lost; (3) that only by a full-scale and energetic program can the potential effects on children of favorable early experiences be assessed, whether children of the poor or of the middle class.

A longitudinal study of the children admitted to the center and of their families is underway. Many aspects of the children's development are measured: intellectual skills; language development; physical growth, health, and disease patterns; social behavior; personality traits. Detailed information about their homes and families is also being obtained. A similar matched control group of 31 children who receive health care at the center, but are not included in the day-care or educational program, is also being carefully followed.

The center provides a unique setting for a broad range of additional short-term studies. A few examples of these are an investigation of the comparative role of visual and auditory stimuli in the imitation of sounds by young infants; investigation of the relationship of the genetic similarity in sibling to the similarity of their developmental progress and personality traits; development and evaluation of educational curricula; investigation of the effects of various television programs on the aggressive and friendly behavior of children.

Thus far, there is reason to be pleased with the progress of the children. As a group they are bright, alert, fond of each other and of the staff. They display a minimum of aggression and a maximum of "joy de vivre." They are verbally adept, confident, and emotionally stable. Although as yet there are too few children involved and the program has been in operation too short a time to bank confidently on the results of formal testing, the findings thus far have been encouraging. The children from disadvantaged homes, in particular, have progressed at a very satisfactory rate, far exceeding the developmental norms for this group.

The affections come to school with the intellect.

John Milton Gregory, in "The Seven Laws of Teaching," Pilgrim Press, Boston, 1917.

PARENT and CHILD CENTERS

WHAT : WHERE
THEY : THEY ARE
ARE : GOING

ALICE V. KELIHER

The motivation for establishing the federally aided program of Parent and Child Centers (PCC's) a little over a year ago came from the realization that many children of poverty, when they entered Head Start centers, had deficits in health, physical development, mental acuity, and language usage dating back to infancy and very early childhood. Nearly half of the first million children registered with Head Start had not seen a dentist; most of them had had no consistent medical care; many had nutritional deficiencies.¹ Few of the children showed evidence of having been stimulated intellectually by being talked to or played with by the members of their families.

When these deplorable facts were reported to President Johnson early in 1966, he immediately set up a Task Force on Early Childhood Education. This group proposed that pilot Parent and Child Centers be established in various parts of the country to demonstrate what could be done to prevent developmental deficits by helping parents both before and after their babies are born and by providing comprehensive health, educational, and social services for infants and toddlers. The President announced the pilot program in his Health Message to Congress in February 1967. A unit of Project Head Start, the program is administered by the Office of Economic Opportunity with the cooperation of an interdepartmental steering committee representing OEO, the Bureau of the Budget, and the Departments of Labor,

Housing and Urban Development, and Health, Education, and Welfare.

The whole PCC program involves only 36 communities and seven of these have not yet reached the operational stage. Therefore, critics are inclined to say that the program represents "just a drop in the bucket." Possibly so. But it may eventually have a widespread effect, for it is an effort to create some new designs to reach and serve children early in their lives, and to involve and train adults in the essentials for child development who have been unaware of the needs and potentialities of infants and very young children. With the Federal contribution to each center limited to the sum of \$185,000 for planning and the first year of operation, a further goal is to set up a manageable but effective program that can be duplicated throughout the country without the expenditure of astronomical sums of money.

The 36 communities selected for participation, with the view of achieving geographic, urban, rural, and ethnic representation, each received \$10,000 for a 6-month planning period before being granted any operational funds. In most instances, the planning money was granted to a local community action committee. In most communities, much of the planning period was consumed in seeking persons to serve on PCC planning committees, which were required not only to include representatives from the various local health and social agencies, but also to be composed, by at least one third, of persons who were liv-

ing in the neighborhoods that were to be served.

Once a local PCC planning committee was formed, it had to establish relationships with community action leaders and Head Start personnel, find office and operating space, and learn what the needs of the people in the neighborhood were, what agencies already existed to serve them, and what special services a Parent and Child Center could most appropriately render. Then the committee had to find a PCC director acceptable both to itself, the community action committee, and the people in the neighborhood—a task made especially difficult by the shortage of people who are qualified by training and experience to work with children and who could comfortably and effectively work in a disadvantaged neighborhood. It also had to get the machinery going for a changeover from a planning committee to a policy advisory committee in which half of the members must be PCC parents or neighborhood residents. The other half are usually representatives of other agencies that serve the community, including both lay and professional persons.

Program design

Thus, building adult and agency relationships necessarily took precedence over designing the programs for infants and toddlers not only during the 6-month planning period, but also in some instances several months afterward. Now, however, the PCC committees are turning from an almost exclusive concern with adult relationships of all kinds to a concentration on the design of the programs for infants and toddlers. In this they will be helped by an OEO-sponsored seminar for PCC project advisors to be held this spring and to be focused on current research and demonstration designs for working with infants and young children that have implications for PCC's.

Though varying in their structures, many PCC's now in operation follow the approach developed at the University of Florida in the research project described in this issue by Ira Gordon. [See page 53.] In these centers, neighborhood residents are trained to become infant educators who go into homes, work and play with the babies and toddlers, and teach mothers to do the same. These family aides help the parents secure stimulating toys and materials for the children. They teach the parents the value of talking with the infant as well as the toddler, and help them get library cards to secure story and picture books to share with their children.

The popularity of this home-based approach may be traced to two origins. For poverty-stricken parents, especially those in rural areas, travel to group meetings is often almost prohibitive, and so the program is taken to them. Secondly, many of the PCC's have experienced delays and difficulty in securing physical setting for their operations, and therefore in order to get going, they carry their work into the homes.

Some PCC's combine two approaches: (1) going into the home and (2) providing a center to which the parents bring their children for group activities or care. However, there is not as much group day care in the PCC's as might be expected. A few PCC's do have day-care centers for infants. One plans to use neighborhood homes for family day care. Another is developing cooperative day-care services with parents as child-care workers both in family homes and in groups at the center.

The emphases in the centers differ. For example, one center is focused almost exclusively on serving teenage unmarried mothers and their children as well as other members in the children's families. Another, focused on teenage parents in a crowded inner city area, plans to establish a neighborhood house to provide opportunities for rest, recreation, and learning, managed by the young parents themselves.

Some PCC's are trying out various ways of grouping children in child-care programs. One places infants under 1 year of age in four different age groups. Another, concerned that older siblings may feel left out, has arranged for them to spend time each week in "alternate homes" programmed for happy experiences. Still another, in a Mexican-American neighborhood where the children have the problem of learning two languages, has divided the 3- to 18 month-old children into three groups, trying different approaches to cognitive development in two of them and maintaining the third as a control group. Another PCC is trying to devise new and better techniques of parent education.

Only a few centers have gone into any kind of "rigid research." The PCC's were advised against

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setting up much detailed research in the first year of operation on the grounds that they needed time to find their way to appropriate services without being restricted by tight research lines. All the PCC's, however, are recording general information on the families being served, program details, and data on aspects of child development.

Parent participation

PCC's are practically unanimous in reporting a high degree of parent participation in planning and operating their programs. In some cases the entire program of activities is organized by the parents of the children served by the center. In these centers PCC staff members consider themselves resources for the parents, to be called on for advice when the parents want it. In other centers the planning is done by the policy advisory committee; and in still others, the staff does more of the planning, usually in response to needs expressed by the parents.

The centers provide the parents with a range of opportunities and services. Among them are—

- General education classes at convenient hours.
- Workshops in nutrition, cooking, sewing, and carpentry.
- Classes in health, safety, and first aid.
- Instruction in the homes or in the center, or both, on ways of stimulating development in infants and very young children. The emphasis is on sensory stimulation and language development. In one center video tapes are made of parents working with their children. When he replayed the tape, one father discovered he was echoing his child's baby talk.
- A "crisis fund" that can be drawn on in extreme emergencies.
- Demonstrations of home improvements and effective care of a house through a "model home."
- A workshop where the men in the family can produce salable arts and crafts traditional in their ethnic group.
- Assistance to fathers' efforts to cultivate crops to augment family food supplies.
- Bathing and laundry facilities in the center for families whose homes have no running hot water.
- Assistance with personal and everyday problems,

sometimes through professional social workers but more often through neighborhood residents chosen for their ability to get along with people and to learn how to make referrals to health, welfare, and other services available in the community.

The foregoing are examples of the many kinds of activities and services for parents in the PCC program. Of course, parents are of necessity intimately involved in the health programs and in the work with the children.

Most of the PCC's are striving for the participation in their programs of fathers, grandfathers, and teenage boys. Nearly all centers have neighborhood men on their policy advisory committees. Some centers have also succeeded in placing men on their staffs—as PCC director, teachers, social workers, family aides, custodians, or in other capacities. Some centers are making special efforts to recruit grandfathers and teenage boys from the neighborhood being served to work as aides in the center, either on a paid or volunteer basis.

Fathers in PCC families are encouraged to improve their occupational status by seeking better jobs, more training, and continued education. One center has already succeeded in helping six fathers move ahead.

Men and boys, especially fathers and brothers of the children being served, are also encouraged to participate in the workshops for making toys and equipment for the center and the families' homes, as are the children's mothers.

A few centers also provide social activities for the men. Indeed some leaders insist that the men need stag gatherings to escape the dominance of their women. In some of these meetings coffee gives way to beer or "better."

One goal of this emphasis on male participation is to provide a male image for the children. Another is to help the men develop a sense of pride in their role as the man in the family and strengthen their leadership as the family head. Another is to help fathers realize that they can enjoy their children and find pleasure in playing with them and in sharing in their upbringing.

Health and medical care

A vital commitment of the PCC program is to secure comprehensive medical care not only for the child but also for his whole family. While some centers—especially those in sparsely settled rural areas—

are still struggling to meet this obligation, others have made dramatic moves. For example:

- One PCC provides the funds for all children under 18 years of age in PCC families to be served by the local children's hospital and all members of the family over 18 to be covered by a voluntary group health association plan.

- Another PCC has arranged for comprehensive health care to be provided by an OEO Neighborhood Health Center sponsored and serviced by a local hospital.

- In another area the PCC has arranged a liaison with a local university medical school that will enable psychiatrists in training to serve members of PCC families where needed.

- A few other PCC's also have psychiatric counseling available. In some there is group therapy. One center is experimenting with "play therapy" for 2-year-olds.

- In one of the Nation's worst "burned out" ghettos, where there are large numbers of Puerto Ricans in the population, the PCC plans to join a group of socially-minded physicians at the city children's hospital in efforts to improve the availability and quality of health services to the poor. In this PCC a group of mothers on the planning committee has conducted a health survey, printed in English and Spanish, to ascertain the community's most urgent health needs.

- Other PCC's are also surveying existing health services, their adequacy, and their style of dealing with poor families. Neighborhood aides on the PCC staff are encouraging families to use existing health agencies. These PCC's are trying to get the agencies to protect the dignity of the families in rendering their services.

- Several PCC's are making special efforts to learn about the nutritional and medical needs of adolescent mothers and their infants. They plan to emphasize health and nutrition counseling.

- PCC's that have been able to arrange for comprehensive health care are also seeing that family planning services are available to those mothers who want them. Or they refer mothers who request such services to existing planned parenthood agencies.

A still unsolved problem is what to do about health care for PCC families in geographic areas where adequate medical services do not exist. Perhaps what

is learned from a survey of PCC experience can be used to guide State and Federal agencies in creating further services to meet urgent needs.

Training

Everyone in the program, from aide to professional project advisor, seems to realize the need to know more about children, how they grow, what their overall needs are, what to expect in normal behavior. As a result, all of the centers are involved in plans for training programs—for staff, for members of advisory groups, and, of course, for the adults in the families of the children in the program. There is need for good source materials to assist with and vivify this strategic part of the program. Readable books, pamphlets, cartoon strips, TV tapes, movies, live TV programs, photographs, first-hand observations of children, all have a place in such training. The problem is to make them available and readily usable.

Such training needs will continue. Many issues and areas of concern do not become evident until staff members and parents try to carry out some of their ideas. At such a time, they are likely to be highly motivated for continuing study. Many PCC directors have indicated that they would like help in planning and conducting the kind of staff meetings in which all levels of personnel will participate as well as in arranging sessions that will appeal to the parents.

Most centers are beginning to plan for career development for their staff members. In some cases where feasible, they are tying in with programs in their areas sponsored by the Educational Projects, Inc., an organization for career development in Head Start.

MOST OF THE PCC's have a long way to go to achieve comprehensiveness in the educational, health, and social services they offer disadvantaged families and children. But they are busy breaking down the barriers to comprehensiveness and showing ways of getting at the child and his family in the period of the child's life most crucial for his development.

As one director described the efforts: "Hardest to put into words, and the most unique feature of our program, is its *spirit*, which has to be experienced rather than talked about."

¹Office of Economic Opportunity, Project Head Start: The Project Head Start, 1965-67: a descriptive report of programs and participants. Unpublished material compiled by the Bureau of the Census.

COMBATING

MALNUTRITION

THROUGH

MATERNAL and

CHILD HEALTH

PROGRAMS

MARY C. EGAN

● In recent months, increased attention has been focused on the problems of hunger and malnutrition in our Nation as a result of citizens' inquiries and studies, congressional hearings, legislative action, and the "stepped-up" activities of many Federal agencies. It seems timely, in view of this heightened public concern, to review some of the efforts to reach mothers and children with nutrition services.

An emphasis on nutrition education for mothers and children may be the key to the health and well-being of present as well as future generations. In fact, the quality of "nutritional imprint" on today's children may determine the nutritional health of the mothers and children of tomorrow.

There are many causes of malnutrition among children, all of them familiar to persons who work in

the public health or welfare field. Some families just do not have enough money in their pocketbooks to buy adequate food. Some simply do not understand that the food they select can make a difference in family health and productivity. Some are still struggling to feed themselves properly with no refrigerator, few cupboards, and only a two-burner gas plate. Some parents completely reject one or more of their children, leaving them devoid of love, food, and other basic essentials for healthy survival. And some children are suffering from a chronic illness that affects nutritional requirements and the body's utilization of food. Frequently, a combination of these forces is at work, and the complexity of the matter adds to the difficulty of effecting solutions.

In attacking any problem, it is important to define its nature and extent and to start with some baseline data. Therefore, the first question in dealing with the problem of malnutrition must be, "What is actually known about the nutrition problems of mothers and children?"

Many gaps remain in the information about the nutritional status of the U.S. population, although efforts have been made over the years to diagnose and evaluate nutrition problems in various parts of this country. Most of the studies that have been carried out have been restricted by limitations on resources for doing the job.

Some recent findings

Recently, however, efforts to delineate the nature and extent of nutritional poverty have been stepped up and new data secured. For example—

- A study of the nutritional status of about 500 children between 1 and 6 years of age selected at random from a 17-county area in Mississippi between November 1967 and March 1968 found that nearly 40 percent, or 200, of them were from families with a reported per capita income of less than \$500 yearly. Comparisons between these 200 children and the 300 children whose families had yearly per capita incomes exceeding \$500 showed that a higher percentage of children among the low-income group had "low" dietary intakes of calories, protein, calcium, vitamin C, and vitamin A and "low" laboratory values for hemoglobin, and serum iron, albumin, vitamin A, and vitamin C. For example, 24 percent of the children in the low-income group had low hemoglobins—that is, less than 10 grams of hemoglobin in 100 milliliters of blood (10 gm./100 ml.) as com-

Based on a paper presented at the annual meeting of the American Public Health Association, Detroit, Mich., November 1968.

pared with 12 percent in the higher income group.¹ This study was part of the pilot phase of a nationwide study of preschool children.

- In March–April 1968 the Children's Bureau carried out a study² to test the feasibility of collecting data on the nutritional status of children through the comprehensive health services projects for children and youth supported by the Children's Bureau in many low-income areas. Information on height and weight was obtained on approximately 17,000 children from birth to 13 years of age. On the basis of comparisons with the Harvard Growth Data,³ approximately 7 percent of the 2- to 6-year-old children were classified as severely stunted in height or weight. Information on the concentration of hemoglobin in the blood, obtained on 13,000 of the children, showed that 28 percent of those who were between 12 and 24 months of age had hemoglobin concentrations of less than 10 gm./100 ml.

- Preliminary data from the Public Health Service national nutrition survey initiated in low-income

A thoughtful and apparently satisfied boy finishes his lunch. Good nutrition education is focused on helping mothers serve children foods that will foster the kind of eating habits that contribute to growth and development.



areas in Texas, Louisiana, New York, and Kentucky indicate an alarming prevalence of those characteristics that are associated with undernourished groups, according to testimony given by Arnold E. Schaefer before the Senate Select Committee on Nutrition and Related Human Needs on January 22, 1969. For example, among findings reported was an "unacceptable range" of hemoglobin levels in one-third of the children under 6 years of age, evidence of vitamin D deficiency in about 3.7 percent of the children under 6 years, and retarded bone growth in 3.5 percent of the 120 children whose wrist bone X-rays had been analyzed.

- On January 10, 1969, the then Secretary of Health, Education, and Welfare, Wilbur J. Cohen, in a statement before the same Senate committee, noted that "public assistance programs serve only about 40 percent of the poor. Further, some States provide in actual assistance payments less than 50 percent of what the State itself considers a necessary standard." He also pointed out that only 45 percent of the families receiving aid to families with dependent children (AFDC) receive food stamps or donated foods from the U.S. Department of Agriculture. In 1967 of the families on the AFDC rolls, 15 percent lived in areas without food stamps or the donated food program.

- Recently, State and local health agencies were queried by the Children's Bureau about their views on the need for additional food among infants, children, and expectant and lactating mothers. A large majority of the replies from these agencies expressed the opinion that such a need does in fact exist among many of the individuals and families they serve. The health agencies indicated a willingness to do all they can to help alleviate the situation.

- A nationwide study of child abuse carried out by investigators from Brandeis University in 1967⁴ demonstrated that, among 5,938 children reported as abused that year, 238 (or 3.9 percent) were suffering from malnutrition.⁵ Their malnourished condition was judged to be the outcome of relationship and personality problems in their families rather than a result of the families' inability to procure sufficient food. In all of the cases, irrespective of socioeconomic status, the child's state of malnutrition was judged to involve elements of intention on the part of the child's caretaker.

- In 1968, nutritionists working with mothers and children in maternal and child health programs were

asked to provide some information about current practices regarding the addition of solid foods to infant diets. Particularly striking in their replies was the frequency of such comments as, "By one year of age, the majority of children are on table foods. Large amounts of breads and cereals, fats, and concentrated sweets (jelly, sugar, and soft drinks) as compared to meats, fruits, and vegetables are being consumed by 1-year-old as well as 2-year-old children." Many young children apparently are eating large quantities of foods that provide few of the essential nutrients other than calories. Such practices may be related to the increasing prevalence of obesity and dental caries in children.

Diversity in attack

The diversity of causes of malnutrition in children obviously calls for a variety of approaches in attacking the problem. One of these involves the complex problem of income maintenance and its implications for economic and social policy. Food costs money, and money for food runs out when the family income is too small to provide for the basic essentials of living—shelter, clothing, utilities, as well as food. But equally important is an understanding of nutritional requirements and how to meet them; and this involves nutrition education, a major aspect of the maternal and child health programs supported by Federal, State, and local governments.

Since experimentation is being encouraged, many different educational methods are being tried in these programs today, those that seem effective being retained and others discarded. Among the promising approaches are the following:

1. *Providing intensive dietary counseling in normal and therapeutic nutrition.* In the 53 maternity and infant care projects and 58 comprehensive health care projects for children and youth being supported by the Children's Bureau in low-income areas, there is a higher concentration of nutritionists and dietitians than is usually found in generalized public health programs. For example, these projects have over 300 positions budgeted for nutritionists, as compared with about 500 such positions budgeted for all of the official State and local public health agencies throughout the Nation.

These comprehensive health and medical care projects afford excellent opportunities to reach mothers and children in low-income families with nutrition education, for they offer nutrition services

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as an integral part of health services. Participating in an interdisciplinary core team, nutritionists work closely with physicians, nurses, social workers, physical and occupational therapists, specialists in speech and hearing, and other specialists. They evaluate the patients' dietary intake and food practices, give individual food and nutrition guidance adapted to each family's level of education, cultural background, and economic level so that the family can carry out their instructions.

These health projects emphasize both the preventive and treatment aspects of nutritional care. For example, in the maternity and infant care project in Minneapolis, Minn., in addition to providing special nutritional counseling to expectant mothers at risk of complications of pregnancy, the nutritionist helps mothers with weight control programs after the birth of their babies. Such service given during the period between pregnancies may help prevent the stress and danger of being overweight or underweight during future pregnancies. Since the patients in both the maternity and infant care and children and youth projects are followed over a long period of time, the nutritionists usually have opportunity to reinforce their teaching and evaluate the patients' nutritional progress.

In working with mothers and children enrolled in the projects, nutritionists along with nurses and practitioners of other disciplines have been experimenting with various educational media and techniques. For example, the Omaha, Nebr., maternity and infant care project is conducting research on the development of programmed instruction in prenatal education. In this project, educational television programs on various aspects of maternal and child health, including nutrition, are shown twice weekly in the prenatal clinics. Patients seen on the remaining clinic days are used as controls in evaluating the effectiveness of this method of teaching.

2. *Focusing attention on the improvement of parents' competence* by increasing their understanding of the

relationship of nutrition to child growth and developing their skills in child care. Maternal and child health departments—through their regular programs and the special maternity and infant care and children and youth projects and also through programs sponsored by other agencies, such as the preschool program of Project Head Start and its pilot program of Parent and Child Centers for children under 3 and their parents⁶—are attempting to develop and reinforce the kind of parenthood that will help prevent deficits in the health and intellectual, social, and emotional development of the child.

In such programs, nutritionists teach parents directly or indirectly through other staff members not only how to buy, prepare, and serve food that will meet nutritional needs but also to understand the significance of appropriate feeding in establishing sound parent-child and family relationships. In addition, auxiliary workers and volunteers who have received some training from nutritionists and who are usually from the same low-income neighborhoods served by the programs work under supervision with individual parents and young people in their homes and in the clinics. According to several of the projects—for example the projects in Cleveland, Ohio, and Raleigh, N.C.—many of these workers have exhibited a great deal of skill in communicating with mothers and other persons in the families being served and often are more effective than the professional staff members in motivating them to achieve a desirable change in food habits.

Various members of the professional multidisciplinary health team also contribute to nutrition education. For example, in a children and youth project in Philadelphia, Pa., two groups of about 15 parents each meet weekly with different team members for 2-hour sessions of open-end discussions. In these groups, where parents are encouraged to talk about food customs, practices, and attitudes and are helped to understand the need for change, many techniques to help their children achieve better nutrition have been developed by the parents themselves.

3. Focusing attention on problems of home management and family economics. Such problems often block a family's ability to follow through on any kind of recommendations for health measures, including nutrition. In many of the comprehensive health and medical care projects for mothers and children and also in clinical programs for mentally retarded children, home economists and supervised homemakers are bringing their skill and knowledge

in home management and family economics to bear directly on many of the difficult problems faced by low-income families. In some of the comprehensive health care projects—for example, the maternity and infant care project in Goldsboro, N.C.—the home economists work with small groups of mothers in the waiting room of the clinic, using all “teachable moments” to illustrate something as simple as how to read the label on cans of baby food or how to make a basic baking mix from donated foods distributed by the U.S. Department of Agriculture.

The home economists also make home visits to patients referred by other members of the health team. For example, a home economist in the maternity and infant care project in Portland, Oreg., recently reported that she had made 22 home visits during 1 month to help families with home economic problems. She told of one family with a retarded teenage mother whom she taught simple housekeeping skills, meal planning, and cooking to improve her ability to care for her family. In Denver, Colo. teaching homemakers in the comprehensive health care projects accompany mothers to the grocery store to guide them in how to buy wisely. Helping families to become wise consumers can sometimes make the difference between an adequate and inadequate food budget.

4. Reaching young people early with nutrition education to lay the foundation for good nutrition practices. I am not referring here to the kind of nutrition education found by Sliepecevic and Creswell⁷ in their school health education study. In that study more than 50 percent of the respondents in a random sample of large, medium, and small school districts reported that “food and nutrition” was a topic emphasized in repetitive fashion in every grade from kindergarten through grade 12. Rather, I am referring to the educational methods being used in many day-care and nursery school programs for young children where nutrition concepts are developed through exploitation of meaningful learning opportunities such as marketing or preparing dishes that are typical of the different ethnic groups represented by the children in the group.

Other efforts to reach young people with nutrition education include the special comprehensive programs for teenage pregnant girls carried on cooperatively by health agencies, social agencies, and school boards.⁸ Nutritionists and home economists serving in these programs devote time to consumer education, food selection and preparation, grooming, child care,

and many other areas of interest and need. Home economists working in these and other programs report that many expectant and actual mothers seem to be particularly interested in learning how to sew, and that an informal sewing class can provide an excellent opportunity for discussions of wise food selection, good buys in food, and many other aspects of nutrition.

Bases for effectiveness

Undergirding the nutrition education efforts in maternal and child health programs are attempts to assess the type and magnitude of nutritional problems, to evaluate the community resources available to deal with such problems, and to work cooperatively with other agencies that can help make nutrition education effective rather than an exercise in futility.

For example, workers in maternal and child health programs know that one can motivate parents to improve food habits and teach them what to feed children, but if the parents do not have access to adequate food, such efforts are in vain. Therefore, they devote a great deal of time and energy to working with all types of community resources for making appropriate food available to children and their families—the food stamp and donated foods programs of the Department of Agriculture, the feeding programs of Head Start and other day-care centers and schools, and public assistance programs—to maximize their benefits to mothers, children, and other members of families. Many of them are now involved in local or State plans for participation in the Supplementary Food Program for Low-Income Groups Vulnerable to Malnutrition, recently established by the Department of Agriculture in cooperation with the Department of Health, Education, and Welfare and the Office of Economic Opportunity, to make selected nutritious foods available to needy infants, preschool children, pregnant women, and postpartum and nursing mothers. (See page 78.)

The measure of effectiveness of any nutrition education effort must be the extent of improvement achieved in food habits. To evaluate a program adequately requires specifically defined goals, some baseline data against which to assess progress, and objective criteria to determine whether a goal has

been achieved. Cognizant of the importance and need for evaluation of their efforts, workers in maternal and child health nutrition education programs are trying to do something about it. In many programs, for example, they have been gathering data on the incidence of iron-deficiency anemia among young children served by the projects that can be used in the future as a base against which to compare the incidence of anemia in children of families that have received nutrition services.

Considerable progress has been made in many families as a result of nutrition education, but some of the old, familiar nutrition problems continue. Many people still do not have the benefits of an adequate diet. Obesity, iron-deficiency anemia, dental caries, and other nutrition-related diseases are still prevalent. In addition, new problems in nutrition are constantly being created or discovered as a result of changes in living patterns, new research findings in biochemistry, medicine, and food technology, and developments in advertising techniques. There will continue to be much to do in nutrition education for mothers and children, but, as it has been said, "Every tomorrow has two handles. We can take hold of it by the handle of anxiety or the handle of faith."²

¹ Owen, George M.: Nutritional status of Mississippi preschool children. (Unpublished report.) (See "Here and There," *Children*, Nov.-Dec. 1968, p. 244.)

² Fomon, Samuel J.: Analysis of data collected from comprehensive health services projects for children and youth, March-April 1968. U.S. Department of Health, Education, and Welfare, Social and Rehabilitation Service, Children's Bureau. Washington, D.C. 1968. (Unpublished report.)

³ Nelson, W. E. (ed.): Textbook of pediatrics. W. B. Saunders Co., Philadelphia, Pa. 1964. (See tables 10 and 11 on pp. 49-53.)

⁴ Gil, David G.: Nationwide survey of legally reported physical abuse of children. In *Papers on social welfare*, No. 15. Brandeis University, Waltham, Mass. 1968.

⁵ ———: A research note on malnutrition of children. (Unpublished paper.)

⁶ Keliher, Alice V.: Parent and child centers—what they are, where they are going. See page 63 of this issue of *Children*.

⁷ Sliepecevich, Elena M.; Creswell, William H.: A conceptual approach to health education: implications for nutrition education. *American Journal of Public Health*, April 1968.

⁸ Howard, Marion: Comprehensive service programs for school-age pregnant girls. *Children*, September-October 1968.

⁹ Hay, Gilbert (ed.): This way to happiness. Simon & Schuster, New York, N.Y. 1967.

NEW ZEALAND'S DENTAL SERVICE for CHILDREN

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Forty-eight years ago, the New Zealand Department of Health adopted the idea of training young girls, through a concentrated 2-year course to accept the responsibility for the routine dental health care of children, as an answer to a need too widespread for the available dental manpower to meet. Through an evolutionary rather than a revolutionary process, the Department has, in the intervening years, developed a national dental care service for children that uses some 1,300 young women so trained to provide the basic treatment. Called the New Zealand School Dental Service, the program has been built up procedure by procedure, technique by technique, building by building, until today it is bringing routine dental treatment to well over 90 percent of the pupils attending the state, church, and other private primary schools in New Zealand and over 60 percent of the children in the nation who are between 2½ and 5 years of age.

The New Zealand School Dental Service is operated entirely by the Government through the dental division of the Department of Health. Through school dental clinics, it gives routine examinations and basic treatment to children from the age of 2½ years until they finish primary school, usually at 12½ years of age. These statements, without further explanation, might leave the impression that dentistry in New Zealand is fully socialized. This is not so. The integration of the school

dental system with private practice is one of the most interesting facets of the program.

The definition of the scope of the service is clear and rigidly observed. Types of treatment not covered in the clinic are made available through private practitioners and paid for by the Government as a health benefit. Payment for specialist work, such as orthodontia, is not included and is the responsibility of the parent.

When children reach secondary school, they are asked to register with the private practitioner of their choice under the general Dental Benefits Program. Here, again, the Government meets the cost of all treatment except that classified as specialist work. Almost all private dentists are available to enroll secondary school pupils, who remain eligible until their 16th birthday. Since there is no provision for dental health benefits for people over 16, three-quarters of the population remain as potential private patients.

Thus, the private practitioners in New Zealand play a specialized role in treating preschool and primary school children; and they receive children from secondary school who have already been trained to accept dental treatment and thereby represent a nucleus of patients whose fees are assured.

Experience has shown that the majority of young people who have been enrolled in the program continue to attend the dentists' offices routinely

after they pass their 16th birthday. A recent survey¹ carried out on 16- to 20-year-olds shows that 67 percent of male patients and 77 percent of female patients continued to report for dental treatment after the Government financial responsibility for payment ceased.

In New Zealand indigent people of any age can get dental treatment through their local public hospital administration. Special dental services are also provided for members of the armed services, for hospital patients, including those in psychiatric hospitals, and for prison inmates.

Perhaps the most frequent question asked about the New Zealand system of dental care is, "How is it possible to prepare a 17-year-old girl in only 2 years of training to accept the responsibility for dental treatment and to carry out basic dental procedures with only in direct supervision from a dental office who may be as many as 200 miles away?" The answer is contained within the history of the system's development and the principles of organization that have been adopted for it.

Beginnings of the program

At the start of the 20th century, dentists in New Zealand were beginning to bring the poor state of the children's teeth to public notice. The widespread need for dental care was reemphasized during World War I, when routine examination of the troops confirmed dentists' suspicions of a high rate of dental

decay and loss of teeth among young people. At that time, the population of New Zealand was only 1,200,000 and dentistry was just beginning to emerge as a major profession.

When in 1920 the Government decided to establish a school dental service, it charged Colonel T. A. Hunter with the task. Colonel Hunter had been director of the Army Dental Corps during the war and was prominent in the then young New Zealand Dental Association. His acceptance of the task initiated the chain of events that eventually led to a completely new concept of dental treatment for the population.

Today the dental service is only one of many rapidly growing government health services. When it was introduced—interestingly, by a conservative government—the idea of government providing a treatment service was not so widely accepted. Moreover, the dental profession was far from unanimous in approving the proposed scheme to train young women to give dental treatment. Colonel Hunter, however, had the vision, enthusiasm, and influence to enable him to go ahead with it. He selected and began training 35 young women as the first school dental nurses.

Colonel Hunter's first thoughts undoubtedly were to alleviate the distressing infection and pain in children's mouths. In those days, headmasters of schools commonly were confronted in their offices with a daily procession of anguished children asking for relief from toothache. At that time, few dentists were available, especially in rural districts, and only a very small proportion of these were prepared to give young children the kind of treatment that would conserve their teeth. Palliative measures were commonly all that were taken and even then only the most persistent toothaches found their way to the busy dental or medical practitioner, or to the pharmacy, which was ill-equipped for such operations. But Colonel Hunter could see the possibility of training young women not only to extract teeth and fill cavities but also to change children's dietary patterns so that tooth decay would be prevented. In fact, it was the preventive aspect of the new program that appeared to give drive to his leadership.

From this strange beginning, the modern New Zealand version of "preventive care" evolved.

In the first decade of the service, treatment was restricted to only a few age groups to keep the patient load to a size that could be managed by the limited staff. However, certain policies were formulated to allow for its systematic growth. What effect the experience of these earlier years had on the destiny of the dental profession makes for interesting conjecture. In 1938, the newly elected Labour Government socialized general medical and pharmaceutical services for all ages. Dental benefits were not included until 1946, when an upper age limit of 16 was set for the patient. The wisdom of this restriction is now evident as over the intervening 20 years the combined efforts of the state service and private practice have only just been able to keep pace with the expanding population.

Over the years, naturally, many changes have been brought about in the interest of progress, but certain features have remained an essential part of the School Dental Service. These stable features include limitation of the number of patients in treatment groups, the securing of parental consent to treatment, and the use of local dental clinic committees.

Controlled patient groups. Before the introduction of the school dental nurses,

few children in New Zealand were receiving systematic dental care. The new organization had therefore to decide on priority groups to receive treatment from the limited staff. The nurses began with the younger children and, through routine appointments, made them dentally fit. New patients from the higher grades were added to the rolls only if taking them on would not prevent the children already on the rolls from being given further treatment in 6 months' time. In this way a controlled group of patients was built up in each clinic. In the fully developed service each nurse has approximately 450 children on her roll, although in some areas receiving the benefit of water fluoridation the figure is more than 700.

Consent to treatment. One of the first difficulties the service encountered was public apathy, and indeed at times public fear of dentistry. Nevertheless, it became apparent that to protect the dental nurse or other operator, no child should be accepted for dental treatment without the parent's consent. A special form was devised for the children to take to their parents, offering treatment for the child on the condition that he attend the clinic regularly and observe the rules for good dental health. Of course, it is not possible for the service

Children in a New Zealand classroom listen to their school dental nurse tell them how to take care of their teeth in a program of the national School Dental Service.





A school dental nurse, one of 1,300 in New Zealand who give basic treatment to children between 2½ and 16 years of age, amuses one of her young patients.

always to apply the latter condition strictly. However, having such a requirement educates the children and parents on the importance of returning for regular reexaminations and keeps the preventive intent of the program before the public.

In spite of these requirements, most of the children in New Zealand receive dental care routinely.

Dental clinic committees. In the early days of the service, the Government did not provide clinic staff and equipment for all school districts. A community would be given nurses only if the local people could provide accommodations suitable for a dental clinic. This prerequisite led to the establishment of local dental clinic committees to look after the local administration, which included not only providing a dental clinic but also making arrangements for cleaning and laundry and, if necessary, finding an acceptable place for the dental nurse to live. The dental clinic committees were also responsible for arranging transportation to the clinics for children from outlying schools at no expense to the department. But perhaps their most valuable contribution was the development of community ac-

ceptance of the program in its early experimental stages.

Today the Government supplies the buildings for the clinics and the funds for running expenses. The local dental clinic committees, however, still play an essential role in the program. As representatives of the parents, they provide a close liaison between the department and the public and give support to the nurses' dental health education program in the schools.

In reporting on its observations of the New Zealand School Dental Service in 1950, the United Kingdom Dental Mission³ called the dental clinic committee "one of the most interesting features of the organization."

Principles and program

Simplicity, standardization, and stabilization are the cornerstones on which the success of New Zealand's public dental auxiliary service is built.

All staff training is given in the simplest form possible. Various techniques are studied and, after trials, a suitable one is selected and taught to the exclusion of all others. For example, the dental nurses are taught to use only one type of amalgam, one type of cement, and one type of synthetic porcelain. Similarly, records and equipment are kept as simple as possible for the sake of efficiency.

After a satisfactory training formula has been standardized, it remains as stable as possible. The three schools for dental nurses have the same curriculum so that when a nurse is graduated, she can take over the instant management of any group of patients in any part of the country and know the routine immediately. New graduates can be placed next to older dental nurses without a conflict of ideas. One centrally controlled store supplies standard equipment and dental materials.

For readers who might be thinking that "the three S's," simplicity, standardization, and stabilization, imply two others—"socialization and stagnation"—it should be explained that the system makes adequate provision for orderly improvement. A research officer attached to the School Dental Service is continually evaluating older methods of working and testing new ones. If the organization decides to change a technique, the new method is simultaneously

introduced into the three schools for dental nurses and an announcement is made through the *School Dental Service Gazette*, an 8-page, bimonthly house organ. Senior officers check the clinics during their next inspection visits to ensure that the new instruction is being carried out correctly.

For purposes of the program, New Zealand is divided into 13 dental districts, which are controlled by the central directorate of the Division of Dental Health. Each dental district has approximately 100 school dental nurses assigned to it and is managed by a principal dental officer, who in the larger districts has a senior dental officer to help him. Both are graduate dentists. A dental nurse inspector assists in the supervision of nonoperating sections of the work. The principal dental officer inspects each school dental nurse in his area at least three times a year. During the inspection visits the dental nurses are given detailed, constructive written reports, which serve as a part of their continuing education.

About 72 percent of the children enrolled in the program have treatment available to them within their own school grounds. Most of the remaining 28 percent of the children have to travel only a short distance for treatment; a few who live in rural areas have to travel as far as 60 miles.

In regard to the standard of treatment, the United Kingdom Dental Mission³ reported: "... the cavity preparation if anything was on the side of perfection and the finish of the filling very good." There is no reason to suppose that this high standard has no been maintained.

Training program

The three schools for dental nurses are situated in Auckland, Wellington and Christchurch. They are run by Government dental surgeons holding university degrees. The characteristics of a promising school dental nurse are in some respects the opposite of those developed through a good university education, in which individual creativity is a predominant goal, for the good school dental nurse must be able to accept discipline and faithfully carry out any instructions given her. She also needs to have a natural ability to manage young children and a high degree of mechanical skill—neither of these

tributes being dependent on a university background. However, a dental nurse cannot be just an automaton. Her duties as a dental health educator require her to be both versatile and vocal. In addition, she must have the rare combination of intelligence and temperament needed for working with a large team.

Each year about 260 girls with at least 3 years of secondary education are selected for training from over 500 applicants. The selection is based on written questionnaires, school reports, and personal interviews.

During the 2 years of training, a student dental nurse works a 35-hour week with 8 weeks of vacation a year, and accepts the discipline of dormitory life. She learns how and when to extract teeth; to fill cavities in both deciduous and permanent teeth, using amalgam and synthetic fillings; and to clean teeth and apply fluoride topically. She also learns the techniques of dental health education from lectures and instruction provided by faculty members of the Polytechnic School and Teachers' College.

Leading members of the dental profession conduct the final examinations. The profession is thereby kept in touch with the training program.

Some results

What are the results of such a comprehensive scheme of dental care for children? Those dentists who have been associated with the New Zealand program for the last 30 years do not need statistics to convince them of the improvement in the condition of children's mouths. Large carious lesions and abscesses, frequently seen in earlier

years, have practically disappeared, and the population is much more conscious of the importance of dental health. When the service first began, there were 72 extractions necessary for every 100 fillings. The ratio of extractions to fillings has continuously improved until today it stands at 3.1 extractions to 100 fillings.

Fluoridation of water supplies, once widely resisted, is becoming more and more accepted by local authorities. Now over 60 percent of the population served by New Zealand's network of reservoirs have the benefit of this measure to prevent dental caries.

The results of early dental treatment are now being seen among the older age groups in the dental program too. Only 8 percent of the young people between 16 and 21 years of age who report for dental care require any type of denture. In 1952 the figure for Army recruits was 28 percent.¹

In helping to achieve these results, the school dental nurses have neither exceeded their prescribed duties nor indulged in any form of private practice. That they have not done so can be attributed to the attitudes developed toward their work during training, and to the standards of conduct demanded of them by the service.

In any country public opinion will allow only a small proportion of the gross national product to be used for dentistry. Any proposal to meet the problem of prevalent dental decay among children found in New Zealand immediately after World War I would have met with failure if it had meant large outlays of funds right from the start. Therefore, the Department of Health began its dental service in a very small way, recognizing the pri-

mary need to educate the public to the advantages of dental health and preventive care. However, if treatment of dental disease had not been offered from the beginning it is doubtful whether the public would have become interested in theories of prevention.

Today the system devised in New Zealand to promote the dental health of children is accepted not only there, but also in many other countries. Through a number of international organizations New Zealand has helped the following states inaugurate similar programs: Hong Kong, Brunei, Saba, Sarawak, Thailand, Ceylon, Singapore, Ghana, Sierra Leone, and New Guinea. Recently dental nurses have been sent to Australia to help in training programs in South Australia and Tasmania.

A word of warning is in order, however. The successful development of such a program in any country depends on the quality of the dental manpower already available, the country's social and economic structure, and the support of the dental profession. Almost from the beginning, the New Zealand School Dental Service has been fortunate in having the full support and active assistance of the New Zealand Dental Association.

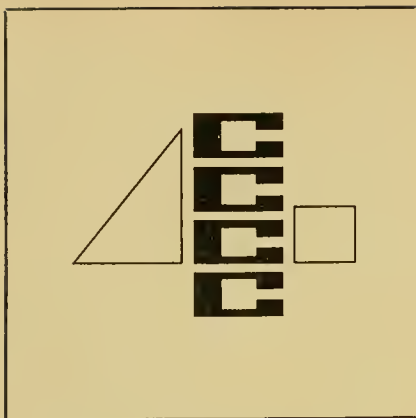
¹ New Zealand Department of Health: Dental health status of the New Zealand population in late adolescence and young adulthood. Wellington, New Zealand. 1968.

² Saunders, J. L.: The New Zealand school dental service: its initiation and development, 1920-60. New Zealand Department of Health, Wellington, New Zealand.

³ New Zealand School Dental Nurses: Report on United Kingdom Dental Mission. Her Majesty's Stationery Office, London, England. 1950.

. . . despite our best efforts we will often fail, volunteers and staff alike. We probably never will realize *all* of our hopes or ambitions. But it is painfully clear now that people who are needed can no longer stand aloof, people with ability cannot remain indifferent. *For if you are not part of the solution . . . you're part of the problem.*

Padraic Kennedy, acting director, Volunteers in Service to America, VISTA Magazine, Fall 1968.



THE 4-C PROGRAM

JULE M. SUGARMAN

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● If two or more people set out to climb the same mountain at the same time, the odds are heavily in favor of them all reaching the top if they travel together. Pooled rations will go further, combined knowledge of the terrain will help overcome hazards, and the shared experience will be of greater benefit to future travelers than one accomplished alone.

This is the reasoning behind one vitally important undertaking of the Federal Panel on Early Childhood. This panel was established in April 1968 at the request of the White House to develop plans for the most effective use of available operating, research, training, and technical assistance funds in ways to strengthen every program. The panel is also responsible for the coordination of all early childhood programs supported by Federal funds. The Office of Economic Opportunity and the Depart-

ments of Health, Education, and Welfare, Labor, Housing and Urban Development, Agriculture, Defense, and Interior (through its Bureau of Indian Affairs), and the Bureau of the Budget are represented on the panel.

There are approximately 4 million children of working mothers in this country today who are less than 6 years old. There are licensed day-care facilities for 500,000 of them.¹ Society has a responsibility to provide sound and effective day-care services not only for these children but for *all* children who need them, regardless of their families' income.

In addition, there are over 2 million economically disadvantaged children² who could benefit from part-day preschool programs, and millions of advantaged children who also need such services.

While buildings, money, expertise, resources, and persons qualified to man the programs are in woefully short supply, what there is to work with will go further and do a better job in meeting the needs if efforts to serve children are coordinated at the Federal, State, and local levels.

As a matter of fact, Congress has instructed the Department of Health, Education, and Welfare and the Office of Economic Opportunity to do just that. Under the 1967 amendments to the Economic Opportunity Act, the Secretary of Health, Education, and Welfare and the Director of the Office of Economic Opportunity have been charged with coordinating all programs under their jurisdiction that are concerned with the provision of day care.

The purpose

In order to carry out these instructions, the Federal Panel on Early Childhood has initiated the Community Coordinated Child Care (or 4-C) Program. The underlying purpose of this program is to encourage agencies providing day-care and preschool services to work together to stretch their resources, cut out waste and duplication, and improve and expand the quality and scope of their services. If they do so, more families will be reached; staff competence will be improved; parents will have a more effective voice in policy and program direction.

What, in essence, does a 4-C Program mean to a community? It means that

early childhood programs run, say, by the local public welfare department, United Givers' Fund, Project Head Start, and a proprietary agency are in a better position to coordinate their efforts, combine to strengthen individual program weaknesses, and share training services. In some communities they may even combine their operation under a single administrative unit.

Communities that make such coordinating efforts may be eligible to receive joint funding from a number of different Federal sources.

As a first step in developing a 4-C Program, the agencies need to agree on their respective missions; which agency will serve which type of children in what parts of the community? This is not to say that overlapping jurisdiction may not be useful in order to give parents choices, but only that such decisions should be arrived at consciously.

Working together

Cooperative efforts can be carried on in the following basic areas:

- Program coordination, such as joint medical, dental, and psychological services; joint action in cultural, recreational, and parent activities; the joint use of staff—for example, the sharing of a nurse, nutritionist, or other specialist.
- Staff development, through common training programs, the exchange of personnel for training purposes, and the visiting of staff members between the programs.
- Administrative coordination, in such ways as joint purchasing arrangements, common business services, and joint personnel recruiting systems.

Programs may arrange for one agency to supply a specific service, such as food catering or group educational activities to all other agencies; referral systems may be established to ease the transfer of a child from one program to another; staff, supplies, and equipment may be loaned between programs; and new or small agencies may assign staff members to work temporarily in an established agency for training purposes.

How are all these things carried out within a community?

First, any public or private organization that wishes to do so convenes a meeting of all interested persons to dis-

discuss the overall concept of the 4-C Program as it might relate to the community's existing programs and needs. Representatives from existing advisory groups of parents (from Project Head Start and other day-care programs) are given an important role in this initial step.

If the consensus of the group is that the 4-C Program should be introduced into the community, a temporary steering committee, with membership drawn from the City Demonstration Agency (a Model Cities Program), if one exists in the area, the local health and welfare council, and other public and private social planning groups, is charged with the responsibility of drawing up a plan outlining the specific areas of coordination it would like to explore. The plan will describe the suggested form of the coordinating mechanism. This may be in existing organization, such as the mayor's planning and coordinating office, a local welfare agency, a health and welfare council, a community action agency, or a Model Cities agency. Or it may be an entirely new agency, to be created for the purpose.

Whichever method is decided upon, the plan must provide for the establishment of a policy committee to act as the governing body of the 4-C Program. This committee will be composed of representatives of public and private agencies that are participating in the program, either as providers of services or as groups interested in the development of programs for children and families. Parents of children enrolled in day-care programs must constitute at

least one-third of the policy committee.

When the plan is completed, a request may be made for technical assistance to the appropriate Federal Regional 4-C Committee. If the request is approved, the Federal Regional 4-C Committee forwards it to the Day Care and Child Development Council of America, which is under contract to OEO on behalf of the Federal Panel on Early Childhood to provide the technical assistance. This assistance can, in some cases, include funds for hiring local planning staff.

The nine Federal Regional 4-C Committees are located in the appropriate regional offices of HEW and are made up of representatives of HEW, HUD, OEO, the Department of Labor, and, in some cases, the Department of Agriculture and the Bureau of Indian Affairs, Department of the Interior.

Because of the deep involvement of State agencies in decisions concerning day-care and preschool programs, State counterparts of the Federal Regional 4-C Committees are also being established. Each community's plan for a 4-C Program will receive a final review from the State committee before being forwarded to the regional office for acceptance and recognition.

Some advantages

While the Federal Panel on Early Childhood is making it clear that the 4-C Program does not provide the community with any additional sources of operating funds, there are certain practical and material advantages to com-

munities that join the program, besides the technical assistance already mentioned.

The Children's Bureau is considering reserving a portion of its funds for short-term training institutes in 4-C communities. These funds can only be granted to institutions of higher education. While funds under the Education Professions Development Act of 1967, administered by the Office of Education, may also be used for training nonprofessional personnel, such funds will not be available until 1970.

In addition, recent trends suggest that future legislation in the day-care and preschool areas may include preferences for coordinated communities.

In the immediate future, the 4-C Program will be operating on a pilot basis, with some 27 communities taking part. Meanwhile, many areas are going ahead with their planning in readiness for the day when Community Coordinated Child Care Programs will be the universal means by which strong and effective day-care services are available to *all* our Nation's children who need them.

¹Low, Seth; Spindler, Pearl G.: Child care arrangements of working mothers in the United States. U.S. Department of Health, Education, and Welfare, Social and Rehabilitation Service, Children's Bureau, and U.S. Department of Labor, Wage and Labor Standards Administration, Women's Bureau. Washington, D.C. CB Publication No. 461. 1968.

²Office of Economic Opportunity, Community Action Program, Project Head Start: Expanding Head Start: a report to the Education and Labor Committee, House of Representatives. Washington, D.C. 1966.

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HERE and THERE



Nutrition

Late in 1968, the U.S. Department of Agriculture launched a new program to provide nutritious food to needy expectant, postpartum, and nursing mothers, infants, and children under 6 in addition to food they may already be receiving under the USDA's food stamp or donated foods programs. Called the Supplementary Food Program for Low-Income Groups Vulnerable to Malnutrition, the program was planned in cooperation with the Department of Health, Education, and Welfare and the Office of Economic Opportunity for persons with special nutritional needs who do not have an adequate food supply.

To receive the supplementary food, such persons must have been determined to be eligible for free or "substantially free" health care or financial assistance through public welfare or health programs—such as the program of aid to families with dependent children, Medicaid, the Children's Bureau comprehensive projects for health care of mothers and infants and children and youth, and the Indian health program of the Public Health Service—and must have an authorization for specific food items issued by a public health worker, such as a nurse or nutritionist, or a physician serving such programs.

Supplementary foods that may be authorized for recipients include, among others, evaporated milk, nonfat dry milk, farina, corn syrup, canned juices, fruits, vegetables, scrambled egg mix, canned poultry, peanut butter, and potatoes.

To get a special supplementary food program underway locally, arrangements must be made between an interested health agency and the office

of State government administering USDA's Commodity Distribution Program, the initiating move coming from either. The costs of the food are met by the Department of Agriculture, but the costs of storage and distribution must be met by local or State governments or other community groups.

To encourage the provision of nutrition education to recipients of the supplementary food, the Children's Bureau and the USDA's Consumer and Marketing Service have prepared special educational materials which may be obtained from either agency.

Public assistance

The regulation of the Maryland State Department of Public Welfare setting a maximum for payments to families—regardless of the size of the family—under the program of aid to families with dependent children (AFDC) was ruled invalid by a three-judge Federal district court in Baltimore, Md., on December 13, 1968. In the case of *Williams v. Dandridge*, the court held that the family maximum grant regulation violates both the Social Security Act and the equal protection clause of the 14th amendment.

Nineteen other States also apply maximum grant regulations of various types in their AFDC programs.

The Maryland maximum grant regulation provides that a family living together as a unit may not receive more than \$250 per month from the AFDC program if living in Baltimore City or \$240 in other parts of the State. In effect, this means that the family cannot receive additional payment for any child beyond the fourth if both parents are in the home, or beyond the fifth if there is only one parent in the home.

The court found that such a maximum on the grant violates the requirement of the Social Security Act that payments must be provided for all eligible persons and is contrary to the act's purpose of keeping families intact. The court also observed that the only purpose of the maximum grant regulation seemed to be to fit the State's provision for its dependent children into an inadequate welfare appropriation.

The suit was filed against members of the State Department of Public Welfare and the Maryland and Baltimore directors of public welfare on behalf of two Baltimore families, each of whom receives maximum AFDC grant of \$250 monthly. The court noted that under standards of need formulated by the Maryland State Department of Public Welfare, one family, consisting of mother and eight minor children, is entitled to \$296.15 and the other, consisting of a disabled father, a mother and eight minor children, is entitled to \$331.50.

. . .

White families accounted for 51.3 percent of all families receiving assistance in the 50 States and the District of Columbia under the Federal-State program of aid to families with dependent children in November and December 1967, according to preliminary figures of a study based on a sample survey by the National Center for Social Statistics, Social and Rehabilitation Service.

The study also showed that in late 1967 seven in 10 AFDC families live in metropolitan areas, with four in 10 living in cities of 250,000 or more. The proportion of families receiving payments of \$200 or above increased from 12.6 percent in 1961 to 28.7 percent in 1967, but the proportion receiving \$10 to \$199 remained at about 40 percent. Families with fathers absent from the home increased from two-thirds in 1961 to almost three-fourths in 1967. In 1967 6.6 percent of the mothers in the AFDC program worked full time and 7.1 percent worked part time. Among other findings of the study: in 19 percent of the families, some member had received family planning services before or during 1967; in 8 percent, at least one family member had been referred for vocational rehabilitation; in 16 percent, at least one member had been enrolled in work or training programs; in 3 percent, at least one child had received

crippled children's services, in 3.4 percent, child welfare services, in 0.6 percent, both; 25 percent of the families participated in the donated food program of the U.S. Department of Agriculture and 22 percent participated in the food stamp plan.

Federal matching funds for legal services provided to recipients of public assistance are now available under a new program of the Social and Rehabilitation Service. In general, the Federal Government pays 75 percent of the cost of such services for recipients of the program of aid to families with dependent children and States or localities pay 25 percent.

The program is optional with the States and is designed to give legal help to recipients of public assistance in a broad range of actions, including landlord-tenant disputes, divorces, and consumer problems; it does not cover criminal and claims cases. Where feasible, the services are to be purchased from the Office of Economic Opportunity and other community legal assistance programs. One of the objectives of the SRS program is the provision of legal services of high quality.

Day care

Three Government agencies—the Department of Health, Education, and Welfare, the Department of Labor, and the Office of Economic Opportunity—have jointly issued requirements for all child day-care programs that receive support from Federal funds. The requirements, developed by the Federal Panel on Early Childhood, apply to all new facilities now and to existing programs within a "reasonable time."

The new requirements are designed to maintain, extend, and improve day-care services, whether they are operated directly by an agency that receives Federal funds or contracted to another agency.

Requirements on grouping of children apply to the following types of child-care arrangements:

- *Family day-care home.* In caring for infants, the day-care home is limited to two children under 2; if one child under 2, no more than five children under 14 can be in the home, including the family day-care mother's own children. For children from 3 through 14 years, no more than six children can be

in the home, including the mother's own children. At least one adult must be in the home at all times, with another adult on call in case of emergency.

- *Group day-care home.* For children from 3 through 14 years, groups may range up to 12 children, but the child-staff ratio must not exceed 6 to 1 for school-age groups or 5 to 1 for preschool groups. No child under 3 may be in this type of care.

- *Day-care center,* which includes one or a number of groups of children divided by ages. For children of 3 and 4 years, there should be no more than 15 children in a group, with a normal child-adult ratio of 5 to 1; for 4- to 6-year-olds, no more than 20 children in a group, with a normal child-adult ratio of 7 to 1; for children of 6 through 14 years, no more than 25 in a group, with a normal child-adult ratio of 10 to 1. Volunteers and teenagers may be used to assist staff members.

Under the requirements, all day-care facilities must be licensed by State authorities, or—if licensing laws do not apply—must meet the standards for such licensing, including safety and sanitation regulations.

The Federal regulations require that each child entering day care be provided a medical and dental examination and followup treatment if needed; educational opportunities supervised by a staff member trained or experienced in child development; and social and nutritional services. They require that the day-care staff be provided with continuous inservice training; that non-professional staff members be given opportunities for career development; and that parents be encouraged to become involved in program planning. They also require that any agency providing day care for 40 or more children establish a policy advisory committee, with parents consisting of at least half of the membership.

Copies of the requirements may be obtained from the Children's Bureau.

Dental care

Eighty percent of the dentists in private practice in a tri-state area around Cincinnati, Ohio, are willing to give dental care to mentally retarded children in families already under their care if the children are manageable in ordinary dental situations, according to a survey carried out in the summer of 1967. The

survey involved interviews with 148 dentists in 15 counties of Kentucky, Indiana, and Ohio. It was conducted by the Tri-State Comprehensive Planning and Implementation Project for Mental Retardation, a voluntary organization directed by Ruth Latimer and supported with a Federal grant from the National Institutes of Health. The dentists reported providing routine dental care to about 1,100 mentally retarded patients each year. Of these patients, 12 percent were under 6 years of age and 82 percent were between 6 and 21.

In a related survey also conducted by the project, a questionnaire mailed to dentists in Hamilton County (Cincinnati), Ohio, showed that 104 dentists there annually care for about 740 mentally retarded patients, of whom 75 percent are under 22 years of age.

As a result of these surveys, the Tri-State Project has prepared a directory of dental services for the retarded, with a list of 85 dentists who accept such patients. (Single copies may be obtained from the Tri-State Project, 2400 Reading Road, Cincinnati, Ohio 45202.) In addition, the Children's Hospital in Cincinnati plans to offer classes for the 154 dentists who indicated interest in the techniques of dental care for the mentally retarded.

Child development

In New Mexico parents are learning how to give their children a better chance for success in school under a Parent Orientation Readiness Program (PORP) operated by local committees and coordinated by the State Department of Education.

The local PORP committees include at least five parents and teachers who work closely with local schools in coordinating activities. The committees keep accurate records of the names, ages, and addresses of all preschool children in the community; they arrange group meetings for parents that present movies, demonstrations on ways to prepare children for school, and discussions. They also seek to get parents of culturally deprived children as well as other children more closely involved with schools.

Home visits are an important part of the program. Parents are recruited and trained to make informal visits to other parents in which they build rapport and stimulate interest in PORP.

The visitors distribute and discuss copies of "Help for Parents in Getting Children Ready for School," a list of 20 suggestions printed in English and Spanish.

Suggestions include: Listen to, talk with, read to, and praise your child; show a real interest in him; take him with you to stores, parks, and other places you visit; give him responsibilities; accept your child as he is, teach him good health and safety habits and good manners, and be consistent with discipline.

R. J. Ingebritson is state coordinator for P'ORP in New Mexico.

Child welfare

A child born out of wedlock cannot be found by a Maryland court to be neglected on the sole ground that he lives with a mother who has another child born out of wedlock, according to a recent decision of the Court of Appeals of Maryland. In a 4-to-1 decision issued on December 3, 1968 (*In re Barbara Jean Cager et al.*), the court reversed a 1967 ruling of child neglect and an order for foster home care by the Prince Georges County circuit court in a case involving three infants born out of wedlock who lived with their mothers and siblings who were also born out of wedlock. The appeals court stated that "the best interest of the child" is the ultimate consideration under the Maryland law in neglect cases that seek to remove a child from his mother's custody. The court also held that neglect proceedings cannot be based on confidential information that mothers are required to supply in applying for aid to families with dependent children. The court pointed out that under both Federal and State regulations information about a father who does not support his child can be used only for purposes directly connected with the administration of welfare programs.

Plans to provide financial aid to some adoptive families have been authorized in California and New York under laws enacted by the State Legislatures in 1968.

Effective September 1, 1968, the New York law authorizes payment through public funds for care and support of a child adopted in the State by a couple in whose home the child was previously

boarded as a foster child. The law is intended to expand the chances of finding permanent homes for "special" children—those in sibling groups, of minority races, of older ages, or with medical problems. It is administered by local public and voluntary agencies under guidelines from the New York State Department of Social Service.

The amount of the subsidy is determined by the local commissioner of social services, who will annually review with the adoptive parents the need for continuing the payment. Medical expenses not otherwise covered may also be provided.

The California law provides for a 2-year pilot program under the State Department of Social Welfare, beginning on January 1, 1969, to encourage the adoption of children for whom permanent homes are not readily available because of age, physical handicaps, or ethnic background. It authorizes subsidies from State and county funds to be paid to adoptive parents of children who have physical handicaps during the pre-adoption placement period and up to 3 years after the adoption has been completed. The total amount of payments under this program must not exceed the amount of foster care payments that would otherwise be provided during the same period.

The law requires the State Department of Social Welfare to carry out a public information campaign on the availability of children for adoption and evaluate its effectiveness; and to analyze the extent to which adoption subsidies increase the number of adoptions, especially among lower income families, and the amount of financial assistance needed by adoptive parents.

Under another new California law, any physically handicapped child who is eligible for medical care under the State crippled children's services at the time of placement and whose handicap is diagnosed before the adoption is granted by the court may continue to receive such services, without regard to the income of the adoptive parents.

After the State of Minnesota revised its child abuse reporting law in 1965, the number of abuse cases reported in Hennepin County (Minneapolis) appreciably increased. The 1965 statute requires doctors, nurses, hospitals, and others who suspect that a child's injury

has been caused by abuse to notify the police and the county welfare department verbally and in writing. Nine cases were referred to the welfare department's child protective service in 1965; 22 in 1966; 34 in 1967.

Of the 60 cases referred to the protective service after the law was revised in July 1965, through December 1967, 23 were referred by the Hennepin County General Hospital; 11 were referred by private physicians; 9 by the police; 4 by a school social worker; each by the department's division of aid to families with dependent children; private hospitals, school nurses, and public health nurses; and one each by relative of the child, a private social agency, a day-care mother, a private nurse, and the welfare department of another county.

These and other figures are contained in a mimeographed report prepared by Edward J. Kosciolk of the department Child Service Division.

Premature children

Evidence that early prematurity exacts a heavy toll in intellectual and physical handicaps has been pinpointed in a study recently completed by the University of Chicago School of Medicine and Clinics. The retrospective study matched 65 children born prematurely in the Chicago Lying-In Hospital between 1952 and 1956 with 65 full-term babies according to sex, twin or single status, type of delivery, parity (mother, onset of mother's pregnancy, and family's socioeconomic status) and compared their developmental status to 14 years after birth. All the premature children weighed less than 1,500 grams (3.3 pounds) at birth. F. Howe Wright, M.D., professor of pediatrics, was principal investigator for the study, which was supported by the Children Bureau.

The research team found that, according to the Wechsler Intelligence Scale for Children, 44 percent of the premature children were mildly or moderately retarded compared with 8 percent of the full-term children; and only 11 percent of the premature children were above average compared with 4 percent of the full-term children. One child, however, who at birth weighed less than 3 pounds, scored 141 on the intelligence scale, second highest in the total group.

Children in both premature and control groups were given physical, neurological, hearing, eye, and psychological examinations by physicians at the University of Chicago Clinics or by private physicians unaware of the subject's birth status; in addition, medical and social histories were taken.

In comparing 59 matched pairs of children, the investigators found that 41 of the controls were taller and 39 of the controls weighed more. The premature children had a greater number of physical handicaps; for example, 35 percent of the premature children and 8 percent of the controls had paralysis, seizures, or deafness; 20 percent of the prematures were partially or completely blind but none of the controls was so affected; 26 percent of the prematures and 6 percent of the controls had other handicaps or diseases. However, the premature children did not show any more neurotic traits (bedwetting, nail-biting, thumbsucking, or rocking) than did the full-term children, as reported by the parents.

In the premature group, 17 percent were unable to attend school and another 17 percent were not doing satisfactory schoolwork; in the control group, only 3 percent were out of school or failing.

More mothers of the prematures had been threatened with miscarriage during the pregnancy and more had received barbiturates and thyroid medication; but more mothers of the full-term children were overweight before and during pregnancy.

Training subprofessionals

Experimental vocational and technical education programs to train subprofessional aides for skilled jobs with career possibilities in public service are being developed by five new research projects supported by the Office of Education with funds authorized under the Vocational Education Act of 1963. The projects are being conducted by the Institute for Local Self-Government, Berkeley, Calif.; the National Education Association, Washington, D.C.; New Careers Development Organization, Oakland, Calif.; New York University, New York, N.Y.; and the Young Men's Christian Association of Metropolitan Chicago, Chicago, Ill.

Before developing the education programs, the projects' researchers will

study the kinds of public service jobs that subprofessionals can perform and the skills they require. They will then assign the tasks and skills to levels on a career ladder consisting of entry-level to professional jobs.

The training courses will be given at the high school, postsecondary, and college levels as part of inservice training or in short-term adult education classes. They will be focused on work in municipal government, law enforcement, social welfare, recreation for the disabled, and audio-visual instruction. For example, the project in Berkeley will develop junior college courses for subprofessional aides in municipal government for work as city inspectors, planning aides, and officials in personnel, finance, and public works departments; the one in New York City will design courses for high school, community colleges, and adult education programs to train recreation aides for work in hospitals, extended medical care facilities, homes for the elderly, and municipal centers.

In addition, the Office of Education is supporting four projects to provide postsecondary and junior college courses to train subprofessional aides for careers in the biomedical, nuclear medical, electro-mechanical, and electro-optical fields. These are administered by the Technical Education Research Center, Inc., in Cambridge, Mass.

Technical training for jobs as oceanographic aides is being given to 120 disadvantaged young men between the ages of 16 and 22 from inner-city areas of Washington, D.C., in an experimental program operated by Ogden Technology Laboratories, Inc., with funding from the Department of Health, Education, and Welfare and the Department of Labor.

The first group of 60 trainees began the 40-hour week, 20-week course aboard the oceanographic ship *The Explorer* at the Washington Navy Yard in January. The final group is scheduled to complete its training in November.

The young men were recruited for the program by and receive allowances from the District of Columbia Department of Employment Security. The testing and final selection were done on the ship by Ogden Technology Laboratories staff members. Because about half of the trainees have less than an eighth-

grade education, the six instructors have devised a special curriculum that combines basic studies in English and mathematics with practical aspects of seamanship, oceanography, and marine biology.

The project has already received requests from marine science industries and government about the availability of oceanographic aides who complete the course.

Nurse assistants

As a result of a 3-year demonstration project in the use of nonprofessional persons as school nurse assistants, the Oakland, Calif., school system has hired 19 nurse assistants to work in elementary schools under the supervision of school nurses. Conducted between September 1965 and June 1968, the project involved the training and use of three nonprofessional persons to handle routine health room duties, thus allowing three school nurses to redirect their services to tasks requiring more of their professional skill. Supported with a grant from the Children's Bureau, it was directed by Doris S. Bryan, with the assistance of Thelma S. Cook as study coordinator.

The three schools in which the demonstration was carried out were matched for control purposes with three schools in which the professional school nurses did not have assistants. All the schools had highly mobile, culturally diverse populations, including a large proportion of students from low-income families. Their enrollments ranged between 800 and 1,100 children each. For the first three semesters, the study cohort consisted of 512 kindergarten children; for the second three semesters, 479 children. Nurses in the three schools in the experiment were asked to spend 50 percent of their working time in providing professional services to the children in the study cohort, including home and school contacts with their parents, but because of other commitments, the nurses actually spent about 38 percent of their time with these children or their families.

Assistants attended a 20-hour course and spent 4 weeks as observer-participants in inservice training. Their duties included giving first aid for minor injuries, testing vision, keeping records, following up on immunizations, and maintaining supplies.

An evaluation committee of experts in school nursing reviewed the findings of the study in May 1968 and concluded that the project met its three objectives by—

- Determining that a planned program of personal contacts by school nurses with parents, both at school and in the home, increases parental action toward maintenance and promotion of the health of the school child and the prevention of illness. Data show that parents of kindergarten children in the experimental group returned health inventories and reports and followed through on referrals about twice as often as parents in the control group.

- Developing a program for full-time nonprofessional nurse assistants who carry out under supervision specific routine functions ordinarily performed by qualified school nurses, thus releas-

ing the school nurse to devote more time to professional activities.

- Determining that the school nurse can actually use the released time for exercise of specialized nursing knowledge and skills, including such professional services as parent counseling, parent education, preventive health activities, work with parents of children with special health needs, and concentrated nursing service for pupils in kindergarten and their families.

A time-and-activity study shows that nurse assistants in the schools in the experiment spent about 30 to 33 percent of their time in direct child care, compared to 6 to 9 percent for school nurses who supervised them and 18 to 26 percent for school nurses in the control schools. Nurses in the experiment spent more time than the control nurses with parents (including home

visits); in health education for students and parents; and in special activities of the project.

Miscellaneous

"There Was a Little Boy . . .," a play for parents about the importance of communication between parents and children, is available for amateur production outside the New York City area from its publisher, the Mental Health Materials Center, 419 Park Avenue South, New York, N.Y. 10016 (\$12 for a production package of 6 copies). The play can be performed by two women and three men; a guide for audience discussion is published with the script. Play Schools Association, a voluntary nonprofit agency in New York City, commissioned Barbara Kay Davidson to write the play for its 50th anniversary.

films on child life

Charges for rental or purchase may be obtained from distributors.

HAVE A HEALTHY BABY. 20 minutes; sound; color; purchase.

Through animation, depicts the process of fertilization and cell division, pointing out the period in pregnancy that is critical in the formation and development of the baby. Emphasizes the importance of early, adequate prenatal care.

Audience: Lay persons, junior high and high school students, professional and subprofessional persons in maternal health services.

Produced by: Church Films.

Distributed by: Churchill Films, 662 N. Robertson Blvd., Los Angeles, Calif. 90069.

A BRIDGE TO ADOPTION. 27 minutes; sound; color; purchase or rent.

Explains the process through which children are placed for adoption by social agencies by depicting the placement of three children with couples with different backgrounds and in-

comes in urban, semi-urban, and rural areas.

Audience: General public, staffs of social service agencies, caseworkers, and others interested in adoption.

Produced by: Harvest Films, Inc., for the New York State Department of Social Services, with a grant from the Children's Bureau.

Distributed by: Harvest Films, Inc., 11 W. 42nd St., New York, N.Y. 10036.

GETTING THROUGH. 20½ minutes; sound; black and white; purchase or loan.

Shows situations in school, at home, and in the community that encourage teenagers to smoke and hamper efforts to help them realize the danger of smoking to health. Raises questions for subsequent audience discussion.

Audience: Teenagers and young adults, teachers, youth workers, and parents.

Produced by: Spectrum Associates,

for the National Clearinghouse for Smoking and Health, National Center for Chronic Disease Control, U.S. Public Health Service.

Distributed by: Film Distribution National Medical Audiovisual Center (Annex), Chamblee, Ga. 30005 (short-term loan); DuArt Film Laboratories, Inc., 245 W. 55th St., New York, N.Y. 10019 (purchase).

TO PLAN YOUR FAMILY. 14 minutes; sound; color; purchase.

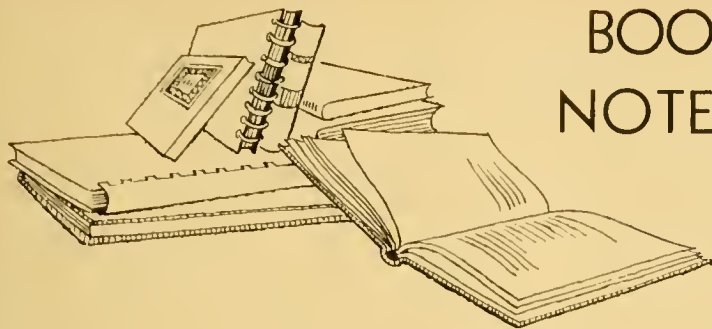
Explains through animation the functions of a woman's reproductive organs, fertilization, and the beginning of growth of a baby in the uterus. Shows methods of preventing conception—the pill, intrauterine devices, rhythm, and mechanical and chemical barriers. Includes interviews with several women who have been using contraceptives successfully.

Audience: Adult and young adult women and men of all educational levels; students; clinic patients; and paramedical workers.

Produced by: Churchill Films.

Distributed by: Churchill Films, 662 N. Robertson Blvd., Los Angeles, Calif. 90069.

BOOK NOTES



come maintenance programs. The author, a professor of social work at San Francisco State College, includes case histories of Soviet social welfare activities she gathered during a 10-year review of literature and trips to Russia in 1960-61 and 1964-65.

While asserting that the Soviet Union has made substantial progress in social services since the 1917 revolution, Dr. Madison points out that the rapid industrialization of the country exacted a high price in human suffering because traditional institutions and values were destroyed before modern replacements were available.

In comparing social welfare systems of the United States and the Soviet Union, Dr. Madison finds some of the same weaknesses—for example, in both countries, rural communities have markedly fewer social services, social insurance does not cover all people for all risks, and there are too few professional social workers to meet the needs of the citizens. In the future, industrialization will be more important than political systems in determining the nature of society and social problems, she suggests.

FOUR YEARS OLD IN AN URBAN COMMUNITY. John and Elizabeth Newson. Aldine Publishing Co., Chicago. 1968. 570 pp. \$9.75.

Using direct quotations obtained during interviews with 700 mothers of children who had celebrated their fourth birthdays within the previous month, the authors describe modern child-rearing practices and attitudes in Nottingham, England. The children were selected on a class-stratified, but statistically random, basis, and included 275 who had been involved in the authors' previous study of 1-year-olds in Nottingham.

Interviewers from the Child Development Research Unit, University of Nottingham, questioned the mothers of the 4-year-olds about such activities as the child's play, eating, and personal habits, bedtime, toilet training, and the mother's use of discipline, her evaluation of the child, the father's role in childrearing, and the family's use of babysitters.

The authors report that parental behavior is modified and controlled by the force of the child's own personality and at the same time by forces of environ-

ment.

The introductory chapter defines early education as "basic socialization" and raises a number of questions pertinent to decisions on how and when such educational efforts are to be applied. Among the issues considered in the research papers that follow are the effects on learning of early stimulation, timing of educational efforts, maternal influences, reinforcement methods, and a responsive environment.

The final chapter summarizes points made in the conference discussions that followed the presentation of the research papers, including these suggested goals: intrinsic motivation for learning, cooperative interaction with others, self-knowledge and self-expression, curiosity and creativity, and complete personality development. Its author points out that two alternative hypotheses, the "deficit model" and the "cumulative model," lead to different kinds of educational efforts for disadvantaged children—the one centered on the development of the specific kinds of skill that the child failed to develop at the appropriate time and the other centered on the goals suggested.

SOCIAL WELFARE IN THE SOVIET UNION. Bernice Q. Madison. Stanford University Press, Stanford, Calif. 1968. 298 pp. \$8.50.

A comprehensive study of the Soviet social service system, this book reviews the historical background and philosophy of Russia's social welfare programs and describes current work therapy programs, family and child welfare services, services for the aged, vocational rehabilitation services, and in-

SOCIAL CLASS, RACE, AND PSYCHOLOGICAL DEVELOPMENT. Edited by Martin Deutsch, Irwin Katz, and Arthur R. Jensen. Holt, Rinehart & Winston, Inc., New York. 1968. 423 pp. \$7.95.

This book, prepared under the auspices of the Society for the Psychological Study of Social Issues, "seeks to clarify the present state of knowledge about social and biological influences on intellectual development," two of the editors say in the introduction. The 11 papers by psychologists are presented in four sections: Biogenetic Perspectives, including a chapter on race and class; Basic Processes in Intellectual Development, including chapters on environment and perception, social disadvantage as related to intellectual and language development, and social class and verbal learning; Social and Psychological Perspectives, including chapters on Negro self-identity, teachers' expectations as unintended determinants of pupils' intellectual competence, and factors influencing Negro performance in the desegregated school; Education of the Disadvantaged, including chapters on environment, development and scholastic achievement, early compensatory education, and environmental intervention in infancy and childhood.

EARLY EDUCATION: current theory, research, and practice. Edited by Robert D. Hess and Roberta Meyer Bear. Aldine Publishing Co., Chicago. 1968. 272 pp. \$6.95.

This volume containing 16 papers on aspects of the early education of children (from birth to age 6) grew out of a 1966 conference held by the Committee on Learning and the Educational

ment and class. As an example of the effect of the child's personality they tell of one mother who held "intelligent conversations" with her older son at age of 4, but romped with her younger son at the same age.

Among the many differences they found in attitudes between the social classes were "consistent and sizeable" differences toward sexual modesty: professional- or middle-class mothers tend to meet a child's curiosity frankly and openly as early as his own questioning dictates; wives of unskilled workers tend to "suppress" sex information by every means possible.

The authors also found different attitudes between classes in regard to the handling of children's quarrels (middle-class mothers more often act as arbitrators while working-class mothers let children settle arguments themselves), table manners (more middle-class mothers "mind" whether a 4-year-old child has good manners than mothers in unskilled working-class families), and more middle-class mothers than working-class mothers are strict about early bedtime and read or tell bedtime stories regularly to their children.

CHILD CARE AND WORKING MOTHERS: a study of arrangements made for daytime care of children. Florence A. Ruderman. Child Welfare League of America, New York. 1968. 378 pp. \$7.50 (paperback).

A change in the current focus of day care from services for children of families with social and emotional problems to services for "normal" families with working mothers is needed in the United States, according to the author of this book, a sociologist who directed a seven-community study of day care from 1960 to 1964.

The author maintains that day care is aimed specifically at one-parent families, the poor, and families in need of casework services, and is seldom available to intact middle-class families. Yet, she reports, the study found that great numbers of "normal, middle-class, intact, responsible families with working mothers" need day care and "even greater numbers" of families want it.

The study was conducted simultaneously in Baltimore, Md.; Caldwell County, N.C.; Cleveland, Ohio; Hartford, Conn.; Memphis, Tenn.; Oakland, Calif.; and Providence, R.I., with local

social welfare agencies as cosponsors. Inventories of all child-care facilities in these communities showed a total of 223 day-care centers, 342 nursery schools, 424 family day-care homes, and 395 afterschool groupwork programs.

The study's findings on child-care arrangements were similar to those found in a survey conducted by the Bureau of the Census for the Women's Bureau, Department of Labor, and the Children's Bureau in 1965. (See *CHILDREN*, July-August 1965, p. 159, and inside back cover of this issue.) Both surveys showed the most common form of arrangement being care by a member of the immediate family, other relative, or maid in the child's own home, and the least common arrangement being group care outside the home. Both showed that large numbers of children are left to shift for themselves (8 percent of the children in the Bureau of the Census study and the children in 7 percent of the arrangements in the study reported in this book).

The author reports that 45 percent of the working mothers in her study said they were satisfied with their arrangements for child care, but 14 percent said they were highly dissatisfied. Care by siblings, care by maids, and children left alone without supervision were behind the greatest dissatisfaction with in-home arrangements. Care in a group facility, although used by only 3 percent of the families, was the most satisfactory arrangement.

THE PARENT OF THE HANDICAPPED CHILD: the study of child-rearing practices. Ray H. Barseh. Charles C Thomas, Springfield, Ill. 1968. 435 pp. \$11.50.

Child-rearing practices among middle-class parents of handicapped children were found to be similar regardless of the type of handicap in the survey reported in this book. Conducted by interviews and questionnaires, the survey reached the parents of 177 children, each with a handicap in one of five diagnostic categories: cerebral palsy, minimal brain damage, deafness, blindness, and mongolism. The mean ages of the children in each group were between 5 and 8 years.

While the parents reported some differences in technique dictated by the nature of the child's handicap—such as the greater use of gestures by parents

of deaf children—in general, the few differences in the child-rearing practices among them appeared to be related to aspects of the parents' personalities rather than to the child's handicap, the author found. He also found that their practices in rearing their handicapped children did not differ appreciably from those they used with their normal children.

The author reports a general lack of knowledge among these parents of modern rehabilitative techniques, particularly in regard to aphasic children and a tendency of parents to find their own way of dealing with their handicapped children through a trial and error method. He, therefore, recommends a program to train parent counselors to work with the parents of handicapped children through the public schools. Problems in communication and learning present more child-rearing difficulties for the parents than sensory deficits in children, he reports.

The author found little evidence to support the "preconceived notion" often held by professional persons that parents of handicapped children are generally "guilt-ridden, anxiety-laden, over protective, and rejecting beings." He also reports that in no case was there any evidence that the parents had withdrawn into social isolation.

for parents

GUIDING YOUR CHILD FROM 2 TO 5. Molly Mason Jones. Harcourt Brace & World, Inc., 757 Third Ave., New York, N.Y. 10017. 1968. 366 pp. \$8.75.

HOPE THROUGH DOING: the rewards of working for your retarded child and others. J. Norman Heard. The John Day Co., 200 Madison Ave., New York, N.Y. 10016. 1968. 187 pp. \$4.50.

LET CHILDREN BE CHILDREN: how modern adults can give wise, loving guidance to boys and girls from infancy through the pre-teen years. Freda S. Kehm and Joe L. Mini. Association Press, 291 Broadway, New York, N.Y. 10007. 1968. 160 pp. \$4.95.

IN THE JOURNALS

Rewarding good behavior

An experiment in the use of a token exchange system to reinforce desirable behavior in extremely aggressive, withdrawn, and autistic preschool children is described by five research workers of the Central Midwestern Regional Educational Laboratories, St. Louis, Mo., in the January 1969 issue of *Trans-Action*. ("Changing the Game from 'Get the Teacher' to 'Learn'," by Robert L. Hamblin, David Buckholdt, Donald Bushell, Desmond Ellis, and Daniel Ferritor.) According to the authors, all the children who participated in the experiment are now "on the road to normality."

The educational system described by the authors not only rewards children materially for each act of desired behavior, but also purposely fails to give them the rewards of attention children with behavior problems have learned to expect from adults—that is, bad behavior is ignored while good behavior, in the form of paying attention and responding to the teacher's request, is rewarded with tokens that may be exchanged for something the child values highly, such as play dough, a ride on the swing, a walk outside, or admission to a movie.

In working with four highly aggressive children, the experimenters had first to train the teacher to turn her back on the misbehaving child while rewarding the other children for every act of cooperation they showed. The result was a gradual improvement in behavior in all the children; but their aggression increased when the system was changed to include not only rewards but also punishment by charging tokens for misbehavior. When the original system of rewards only was restored, the aggressive behavior sharply declined. Similarly, a change in the system to reward the children only with signs of approval, continuing to ignore misbehavior, was followed by a rise in aggression, which again fell off when the material rewards were reinstituted.

The authors report similar results in

experiments with withdrawn, nonverbal children—some of whom were later complained of by their teachers or parents for "talking to much"—and with children exhibiting the bizarre behavior associated with autism.

All the children, they report, improved not only in behavior, but also in IQ scores. They also report that when the token exchange system was used in teaching reading to a preschool group of normal children, 2-year-olds learned to read as fast and as well as 5-year-olds.

Combating malnutrition

Today some 276 million children are suffering from serious malnutrition in 29 developing countries, according to a statement of the Committee on International Child Health of the American Academy of Pediatrics, published in the January 1969 issue of *Pediatrics*. It points out that protein-calorie malnutrition coupled with infection is the greatest killer of infants and young children in the world today as well as the greatest cause of retarded growth and development.

In the statement, the committee maintains that the eradication of malnutrition will require measures to effect broad technological and social change so that nutritious food will pervade the usual channels of marketing. Under present conditions, however, it points out, food must be shipped into the developing countries from the United States if human need is to be met. It therefore recommends certain guidelines for such shipments. In brief, they are:

- Except in cases of emergency, food from the United States should be donated only to support a long-range national plan for meeting national food needs in the developing countries.
- Such foods should not interfere with the promotion of breast feeding or compete with local nutritious products.
- The foods should contain nutrients otherwise unavailable to children in the quantities needed.

- The foods should be tested for safety, efficiency in inducing growth, acceptability, and actual use.

- The foods should be distributed so as to reach children under 2 who have already experienced some degree of malnutrition or live in areas where malnutrition is prevalent.

Diagnosis in utero

The theoretical possibility that physicians may one day be able to treat certain metabolic diseases, such as galactosemia, in utero is suggested in an unsigned article in the January 24, 1969, issue of *Medical World News*. ("Enzymes in Amniotic Cells Tell Tale of Defects Before Birth.") The article reports on techniques recently developed by two physicians at Northwestern University for determining the presence of genetic disease in a fetus by measuring the enzyme activity of the amniotic fluid cells.

According to the article, the physicians, Henry L. Nadler, pediatrician and geneticist, and Albert Gerbie, obstetrician, have noted that the best time for such analysis is between 12 and 14 weeks of gestation when enzyme activity is highest in amniotic fluid. They are reported to be now working to define normal levels of enzyme activity at various stages of gestation. For example, they have found differences between males and females in the activity of an enzyme known as glucose-6-phosphate dehydrogenase.

Thus far, the article reports, the techniques developed can only determine whether certain genetic defects have been transmitted to the fetus by a carrier, but Dr. Nadler believes it may stimulate the development of treatment techniques which will make physicians "directly responsible for the care of the fetus during its 9 months in utero."

Group care

Children reared in five diverse group care programs—a children's village in Austria, different kinds of children's homes in Poland and Yugoslavia, and Israeli youth villages for teenage immigrants and the youth groups in Israeli kibbutzim for adolescents from deprived families—appear to show little or no intellectual or psychosocial deficiencies when compared with controls

from family environments in the same countries, reports Martin Wolins, professor of social welfare at the University of California, Berkeley, in an article in the January 1969 issue of the quarterly *Social Work*. ("Group Care: Friend or Foe?")

In reexamining the premise that "no group care can be good," the author and his associates tested a number of assumptions about the intellectual, personality, and value development of group-reared children. In 1964 and 1965, batteries of tests were given to 485 children in the five different group care programs and to 304 children reared at home. The study settings ranged in "proximity to a familial model" from family-like cottages with nine children and a motherly caretaker in the Austrian *Kinderdorf* to the youth

group in an Israeli kibbutzim consisting of almost 40 teenagers who entered the group in early adolescence. The author observed that in each instance the adults involved regarded the setting as a desirable place in which a child may grow up successfully. "In every instance," the author says, "the staff has accomplished its objective of emulating the parental home or, if that is its choice, drawing a model quite different from it."

Dr. Wolins lists six conditions of group care conducive to good results in changing values and overcoming the effects of previous deprivation in a child: expectations of success; a permanent and unequivocal program and a simultaneous commitment to rear each new child to maturity, social integration within the large milieu, peer im-

pact, socially constructive work, and ideology offering moral anchorage. He concludes that the American professional "must somehow surmount the conflict he experiences around labor, ideology, adolescent peer groups, and the dysfunctional aspects of a well-loved theory."

correction

The article by Helen M. Wallace and associates, "Comprehensive Health Care of Children," abstracted in the "In the Journals" section of the January-February 1969 issue of *CHILDREN* (page 42) was inadvertently credited to the wrong journal. The article appeared in the October 1968 issue of the *American Journal of Public Health*, not *Public Health Reports*.

READERS' EXCHANGE

ANDRONICO AND GUERNEY: Comments on commentary

We welcome the opportunity to respond to the stimulating comments that appeared with our article in the January-February 1969 issue of *CHILDREN*. ["Case Conference: A Psychotherapeutic Aide in a Headstart Program: I. Theory and Practice," by Michael P. Andronico and Bernard G. Guerney, Jr.; "II. Commentary," by Lois Barclay Murphy, Albert J. Solnit, and Jacob R. Fishman.]

We find ourselves in general agreement with Jacob Fishman's comments regarding the general usefulness of nonprofessional persons in service programs and the desirability of providing career ladders. In regard to career ladders, we can only say that if one were to wait until an entire hierarchy of related jobs is established before beginning to use nonprofessionals, many opportunities for their effective utilization would be missed. Sometimes opportunities for a nonprofessional person's

advancement can best be determined as a program proceeds.

With respect to another of Dr. Fishman's points: Clearly further research is needed to determine what forms of therapy are best suited to what problems. We are eager to see other therapeutic methods tried with the use of nonprofessionals and are in fact exploring some ourselves; but we would like to point out that the method proposed by us in the article is one specifically designed to provide the combination of concern, warmth, and firmness that Dr. Fishman notes is so often lacking in the background of ghetto children. It is also one that lends itself to teaching nonprofessional persons (as well as anyone else), because correct in contrast to incorrect types of response are much easier to describe and identify than they are in other therapeutic methods.

We find irrelevant, or are in disagreement with, all of the objections to our article raised by Albert Solnit. Unfortunately, the space allotted to us here

does not permit the lengthy response that would be required to answer them. We suggest that interested readers look up the articles referred to in the footnotes of our article, where they will find answers to all of the pertinent points at issue. We will only add that both clinical observations and empirical measures obtained since those articles were written support our rationale for the effectiveness of filial therapy, rather than Dr. Solnit's rationale for its ineffectiveness.

If Dr. Solnit wishes to call the procedures "educational" instead of "therapeutic," we have no very strong objections. As many theorists are now saying the fewer the theoretical and conceptual barriers erected between that special kind of education of cognition, emotions, and perceptions labeled "psychotherapy" and other types of education the better it will be for the field of psychotherapy and also for education. We are convinced that the kind of interpersonal atmosphere that promotes the effectiveness of psychotherapy is the same kind of atmosphere that promotes learning in other educational situations.

Thus, we are in accord with the views expressed by Lois Murphy (and also Dr. Fishman) that it would be highly desirable for teachers to be aware of

certain psychotherapeutic principles and practices that they might find useful in their daily work with children. The delicate attunement to the child's individual needs and readiness for involvement, sensitivity to the meaning of his choice of play materials, respect for his inclination to work through his problems in his play, and the attempt to look beyond words to underlying feelings, mentioned by Dr. Murphy as essential for therapists, are central to Rogerian play therapy.

We feel that there likely will always be a significant number of children who, before or along with group experience, would benefit from the kind of special individual attention that a psychotherapeutic aide could give. However, we agree with the idea that the more teachers can apply such skills in everyday class activities, the more their pupils will advance in cognitive and emotional growth. In fact, public school teachers who have had training in the methods of filial therapy have found it very valuable in their work. Thus, Head Start teachers might also find it useful in their work.

However, the trainer of a nonprofessional person must be *specific* about *how* to become more sensitive, *how* to become better at understanding emotional communication, and *how* to become better at conveying acceptance. Moreover, there is no substitute for allowing nonprofessionals to perfect and reinforce these skills *gradually* under supervision. Attempts to train parents, teachers, or aides simply by saying "*be empathic*," or "*be empathic all at once with every child and all the time*" are certain to end in disappointment.

Exposition of specific principles and rules to adhere to, demonstration, response-by-response instructive feedback, providing the opportunity for the trainee to engage in time-limited practice sessions, and close, extensive professional supervision are at the heart of the filial therapy and psychotherapeutic aide concept. The individual play periods are important because they permit the child to express his feelings and work through his conflicts and problems. But they are also important because they provide the adult with an appropriate setting and vehicle for acquiring and practicing new and very difficult interpersonal skills through which he can develop a special growth-stimulating kind of therapeutic rela-

tionship with a child. Only extensive experience and practice of this nature can set the stage for generalization to other times and to other children.

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SENN: *Difference in convictions*

Milton J. E. Senn, in his incisive article, "Early Childhood Education—For What Goals?" (CHILDREN, January-February 1969), reminds us that developmental psychology and early childhood education are together undergoing one of those periodic churnings in which various ancient views reappear as revolutionary new approaches. In fact, neither "cognition" (Piaget and Bereiter) nor psychoanalysis (Spitz or Deutsch) is new—new, that is, in the sense of offering us new goals for education or new developmental principles. Basically, we have an old controversy in new clothing (but even some of the clothing is a bit tattered and torn), one, as Dr. Senn says, between "structured" (and speeded up) teaching methods and "flexible" (and leisurely) methods.

But surely the educational goals of the two camps—regardless of which camp is to be manned by the good guys—are not different, and Dr. Senn confuses me when he puts the matter in terms of goals. Surely both camps seek an outcome in informed, curious, intelligent, stable, and humane men and women. The true differences lie in the various convictions about what the educator (or psychologist) at the other end of the pendulum's swing is leaving out: Dr. Senn thinks (as I do) that the "structured" folk too often omit consideration of the nonintellective aspects of development: in turn, the new converts-to-the-cognitive seem to think that Barbara Biber's kind of nursery school is a warm, friendly nest for fostering good human relationships but with no concern for facts or thinking.

But I am perfectly willing to view the issue strictly in terms of cognitive development and to assert that the "flexible" approach—the richly stimulating, choice-giving nursery school—will produce better *cognitive* results than the

"structured" approach, with emphasis on drill in selected, delimited content areas and the implication that if I haven't taught it you haven't learned it. Moreover, I feel that there is solid evidence to support my assertion—and if I am reading the evidence with bias, so is everyone else. Incontrovertible findings are lacking in this field.

My greatest concern with teaching methods like those of Bereiter and Engelmann is that they offer the child a *cognitively barren* preschool experience. It is not just the emphasis on how to say it; not just that the teacher selects what is to be talked about, but the stultifying, repetitive narrowness of content that troubles me, in the same ways that I am troubled by the third grade classroom in which 27 children, in turn, read the same paragraph of the reader aloud.

Skills are like knives and forks: they are tools, but they don't supply a meal.

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Pendulum askew

Dr. Senn's article on early childhood education is a well-stated, elder-statesmanlike caution to impatient enthusiasts who seek demonstrable results immediately. It reminds us that the growth of a child is much more than mastery of a few discrete skills, and underlines the complexity of the task of preschool education.

We can profit from Dr. Senn's reminder that the pendulum has swung too far toward ever-earlier stimulation of the child, regardless of his individual nature, and at the same time in an ever-narrower arc, confined to intellectual development alone. The fashion in research topics—given impetus by those who grant Federal funds and those who direct academic theses—seems today to favor a tidy design that appears to control all the variables because the questions asked are so minuscule. Dr. Senn is right in cautioning preschool educators to avoid construing into cosmic proportions achievement in understanding a small part of the organism. However, we are still in such a beginning stage of learning how children *do* learn that we must take one small clearly defined step at a time.

As a member of "the establishment" in early childhood education, I must admit that my training emphasized the

social and emotional growth of children and gave very short shrift to the means of stimulating children intellectually. "Cognitive development" was almost a forbidden phrase, probably because of the failure of early studies to show any long-term gains in intelligence as a result of attending nursery school. Those who believed, in spite of these studies, that nursery school was good for children undertook to give their pupils a good start in other realms. The sharp criticism of present research workers has been salutary for the field. Members of the establishment have covertly moved toward a more wholesome emphasis on the intellectual potential of the early years because they have been forced to examine what the nursery school was doing in this sphere. When I visit a nursery school today that

has not acceded to the last decade's trend to emphasize learning along with social and emotional development, I am frankly surprised to see how much it differs from the more modern nursery school.

Actually, however, I think that the goals of the two groups Dr. Senn identifies are not widely disparate. Parents, teachers, even research workers everywhere have such patently laudable goals as encouraging "creativity and individuality," stimulating "curiosity and initiative in children," and helping "children find themselves as individuals—learners, doers, persons with feelings, increasing clarity as to their identities and appropriate roles in life."

One of the greatest frustrations for people who seek to create good environments for children is in devising the

means to achieve these goals. How to plan a curriculum to give children the kind of experiences that will produce these intended results has long evaded the most dedicated of educators. Moreover, our evaluative instruments to measure the qualities sought seem to remain as crude as our efforts to measure real intellectuality as opposed to intelligence. We simply do not have very solid information about how to create environments which are guaranteed to produce creativity, or curiosity, or clear sense of identity, nor do we have instruments which will evaluate environments in these terms.

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guides and reports

CHILD WELFARE LEAGUE OF AMERICA STANDARDS FOR ADOPTION SERVICE: REVISED. Child Welfare League of America, 44 East 23d St., New York, N.Y. 10010. 1968. 99 pp. \$2.

The first revision of the League's standards for adoption services originally issued in 1958.

REPORT TO THE NATION ON CHILDREN AND YOUTH. Ruth Stout Wright. National Committee for Children and Youth, 1145 19th St. NW, Washington, D.C. 20036. 1968. 135 pp. \$2.75.

Describes developments at local, State, and national levels to follow up the 1960 White House Conference on Children and Youth.

THE POLICE ON THE URBAN FRONTIER: a guide to community understanding. George Edwards. Institute of Human Relations Press, The American Jewish Committee, 165 East 56th St., New York, N.Y. 10022. 1968. 90 pp. \$1.

Discusses the role and problems of

the police in urban areas and offers suggestions for steps to better relations between the police and the Negro community.

FILM RESOURCES FOR SEX EDUCATION. Sex Information and Education Council of the U.S., 419 Park Ave. South, New York, N.Y. 10016. 1968. 27 pp. 50 cents. Discount on quantity orders.

Lists 49 films on biology and reproduction, maturation, dating and marriage, social problems, and school and community action.

PROCEEDINGS OF THE FIRST CONGRESS OF THE INTERNATIONAL ASSOCIATION FOR THE SCIENTIFIC STUDY OF MENTAL DEFICIENCY (Montpellier, France, Sept. 12-20, 1967). Edited and distributed by B. W. Richards, St. Lawrence's Hospital, Caterham, Surrey, CR3 5YA, England. 1968. 982 pp. \$20, plus postage.

Includes full text of 88 of the major papers presented at the conference and abstracts of the remainder, representing

over 500 authors from some 40 countries. Some of the papers are in French, some in English, with summaries in the other language.

A HANDBOOK OF HEALTH EDUCATION. Department of Education and Science. Her Majesty's Stationery Office, London, England. U.S. Distributor: British Information Services, 845 Third Ave., New York, N.Y. 10022. 1968. 184 pp. \$3.

Discusses the historical development of health education in England, the school's role, community health, and health education for youth, adult parents, and teachers.

NATIONAL RESEARCH CONFERENCE ON DAY PROGRAMS FOR HEARING IMPAIRED CHILDREN. Ann M. Mulholland and George V. Fellenz. Alexander Graham Bell Association for the Deaf, The Volta Bureau, 1537 35th St. NW, Washington, D.C. 20007. 1968. 168 pp. \$3.

Contains the papers, summaries, discussions, and conclusions of a conference on nonresident school programs for children with hearing impairment and resultant recommendations for comprehensive State and local programs.

MAY • JUNE 1969

children

Effects of Congenital Rubella

Learning To Hear Black Youth

Working With Delinquent Boys

Children Living With Relatives



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A prize-winning picture taken by a 17-year-old high school youth of one of his neighbors in Washington, D.C. The photographer, John Davies, received his training at the New Thing Art and Architecture Center in Washington, an organization devoted to raising the level of consciousness of the black community through cultural activities. The New Thing conducts workshops for young people in film-making, African dance, jazz, storywriting, drumming, and sewing, in addition to photography. John Davies' entry was one of 30 winners in a nationwide contest sponsored by the National Association of Photographic Manufacturers in cooperation with the President's Council on Youth Opportunity.

children

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The material presented here is based, in large part upon the experience gained at The Johns Hopkins Medical Institutions during the followup of two overlapping groups of children born in 1964 and 65. The larger group consists of about 1,350 children born to women enrolled prenatally in the Johns Hopkins Collaborative Perinatal Research Project, part of the nationwide Collaborative Perinatal Research Study sponsored by the National Institute of Neurological Diseases and Stroke. The smaller group includes about 300 children with congenital rubella followed as part of the Johns Hopkins Rubella Study. Preliminary results of these studies have been reported in 1966, 1968, and 1969.¹⁻⁹



On successive days in October 1964, two infants with similar abnormalities were born at The Johns Hopkins Hospital in Baltimore, Md. These infants, Richard and Jean, were small for being full term. They had extensive hemorrhagic skin rashes, low counts of blood platelets (substances that affect blood clotting), congenital heart disease, small eyes with glaucoma and cataracts, enlarged livers and spleens. Subsequently, both were found to be mentally retarded, and one, Richard, to be cerebral palsied and deaf. These conditions were compatible with the symptoms of congenital rubella (German measles).

Indeed, the prenatal histories of these infants showed that both their mothers had had rubella during early pregnancy, one on the second day after conception and the other on the 60th day. These mothers were participants in the Johns Hopkins Rubella Study, and serologic tests had supported the diagnosis of maternal rubella. Rubella, usually a benign infection in children and young adults, can cause devastating fetal and neonatal defects when it occurs in a woman early in pregnancy. Rubella virus was found in cultures taken from many sites in Richard and Jean.

Variations in the clinical picture presented by these two infants became commonplace in our nurseries during the next few months. We remembered seeing a few babies with similar rashes, but without eye lesions, in the preceding months.

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RUBELLA

and its aftermath

JANET B. HARDY, M.D.

Richard was the source of infection for a small outbreak of rubella among susceptible student nurses and attendants at Johns Hopkins.¹⁰

The increase in births of infants with abnormalities at our hospital was being duplicated in other medical centers along the eastern seaboard. Between September 1964 and March 1965, many thousands of "rubella babies" were born in the United States, in the wake of the major rubella epidemic that had occurred in late 1963 and early 1964. In the Eastern United States, the epidemic peak was reached in March and April 1964. Babies who showed the effects of rubella at birth the following fall and winter had been in the early stages of intrauterine development when their mothers had the disease. The nationwide rubella epidemic left an estimated 20,000 to 30,000 children with handicaps caused by congenital rubella.

Baltimore has had a small flurry of rubella each subsequent spring. In at least two instances, the outbreaks seem to have spread from neighboring military installations.

Much has been learned about congenital rubella as a result of clinical and epidemiologic observations of the affected children and their mothers, supported by the use of two specific diagnostic tools—viral isolation and serologic tests.

Congenital heart disease, cataracts, and deafness were a triad of conditions already known to be characteristic of congenital rubella when Richard and Jean were born. While other facets of the disease—such as the rash, low platelet count, and glaucoma—seemed new to us, we were intrigued to find that these had been described in the medical literature of Aus-

tralia in the early 1940's.^{11, 12} To a large extent, however, these conditions had been overlooked in the continuing controversy about the extent of fetal risk from rubella.

On the basis of their retrospective studies Gregg,¹¹ Swan,¹² and other Australians had described an extremely high rate of defects (80 percent) in infants whose mothers were known to have had rubella during the first trimester of pregnancy, and a considerably lower rate in infants whose mothers had rubella just before conception or in the fourth month of gestation. In subsequent studies investigators in America,¹³ Scandinavia,¹⁴ and Great Britain¹⁵ found a much lower rate of defects (10 to 20 percent) in infants whose mothers had rubella in the first 3 months of gestation. The question of bias was introduced when the retrospective and prospective studies were compared. The issue was beclouded by two other factors:

1. At the time of these studies, diagnosis of rubella was based entirely on clinical findings. Rubella could

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not be reliably differentiated from a number of other viral diseases characterized by rash, some of which are not known to harm the fetus.

2. Although subclinical rubella produces no rash or other recognizable sign of disease, it may cause just as severe damage to the fetus of the woman infected in early pregnancy as overt forms of rubella. Thus, some women who have had no history of rubella during pregnancy have given birth to babies with abnormalities.

Late in 1962, the rubella virus was isolated independently by two groups of investigators: Weller and his coworkers¹⁶ in Boston, and Parkman and his associates¹⁷ at Walter Reed Hospital in Washington, D.C. The isolation of the virus and the means of growing it in monkey kidney tissue cell cultures led to the rapid development of a series of laboratory tools for the specific diagnosis. By 1963, serologic tests were being used to diagnose rubella both in postnatally acquired disease and in infants congenitally infected in utero.

In postnatally acquired rubella, rubella virus can be recovered from the patient for a relatively short

time, usually from a few days *before* the rash appears until 1 to 4 weeks after it disappears. In prenatal rubella infection, the fetus harbors the virus for many weeks or months. Rubella virus has been recovered at birth from the placenta and from the throat, urine, and rectum of full-term babies, including some otherwise apparently normal babies whose mothers had rubella early in pregnancy. It has been recovered from the eyes and white blood cells of some severely affected babies 2 or 3 years after birth. Babies excreting virus from the throat and in the urine are infectious and should be isolated from susceptible persons, particularly pregnant women. Virus excretion does not persist for long in mildly affected infants.

In postnatally acquired rubella, protective antibodies against the disease can be detected in the bloodstream as the acute stage of the infection subsides. Serologic laboratory tests for active rubella involve comparison of the concentration (titer) of antibodies in two serum specimens drawn 10 days to several weeks apart. Tests for rubella antibodies must be conducted under carefully standardized conditions. They are quick and fairly inexpensive to perform.

In congenital infection, the fetus is capable of producing rubella antibodies in response to infection—at least during the second half of gestation. A positive diagnosis of rubella can be made by the isolation of the virus from the infant at birth or during his first few months, or by the determination of specific serum antibodies after the child is 6 months of age.

The general serum level of IgM (immunoglobulin M) at birth can be helpful in diagnosis. A level above 20 milligrams per 100 cubic centimeters of blood serum suggests intrauterine infection,⁶ although an elevated IgM level does not indicate rubella or any other specific infection, and the absence of an elevated level at birth does not rule out congenital rubella. In a study of IgM levels in blood from the umbilical cords of 88 children with rubella, only 12 of the more severely affected had elevated levels. In the same study of 97 affected children between 1 and 6 months of age, half had elevated levels.⁶

Managing the child

Richard, now 4½ years old, has had almost all possible handicaps associated with congenital rubella (See box, page 93.) He is now very small for his age and has severe auditory, visual, and mental handicaps, mild cerebral palsy, and his right leg and foot are appreciably smaller than the left. Rubella virus

Handicapped visually and aurally by congenital rubella, Richard, at age 3 years and 9 months, is approximately 10 centimeters (4 inches) under the average height for boys of his age, as this picture shows.



THE CONGENITAL RUBELLA SYNDROME

as demonstrated by one infant whose mother had rubella on the 60th day of pregnancy

- Low birth weight (5 pounds) for pregnancy lasting 40 weeks.
- Sickly infant with petechial rash (minute skin hemorrhages).
- Cataracts requiring surgery.
- Congenital heart defect requiring surgery.
- Enlarged liver and spleen.
- Thrombocytopenia (platelets in the blood abnormally low).
- Abnormalities in the long bones detected by X-ray.
- Pneumonia.
- Diarrhea.
- Failure to gain and grow at a normal rate.
- Inguinal hernias requiring surgery.
- Neurologic abnormalities.
- Profound hearing loss requiring two hearing aids.
- Severe mental retardation.

job of \$75 to \$80 per week. Although bills for medical care have been paid by the State crippled children's program and other sources, the cost of transportation to hospital clinics and special educational facilities has been an almost impossible burden on this family. Another serious problem has been the lack of outside recreational activity for the parents, who have been completely tied down by Richard and his little sister.

One of the major problems in the health management of a child handicapped through congenital rubella—and one which is all too frequently overlooked—is the psychiatric impact of the child's condition on the parents. Feelings of guilt, rejection, and anxiety often lead to despair, breakdown in family relationships, and hostility to those who try to help. The tremendous financial burden on parents whose incomes are just above the eligibility limits for service under the State crippled children's program and other forms of Federal and State aid also affects the family stability. We know of an instance in which one parent was apparently driven to suicide. Other parents have required psychiatric care.

The 1963-64 rubella epidemic continues to exact a large toll on community resources. For example, Richard will never be fully self-supporting. At a conservative guess, he may cost the community more than \$200,000 during his lifetime for medical care, rehabilitation, special education, and custodial care.

As multiple handicaps are characteristic of congenital rubella, a multidisciplinary approach is important in management. Repeated evaluation is desirable because the condition of the handicapped child is *not* static, particularly during the child's first 2 or 3 years. Ideally a diagnostic team approach provides:

1. Pediatric evaluation to determine the presence of any manifestations of chronic rubella infection and malformation that may occur, and to assess physical growth.
2. Audiologic evaluation to detect problems in the communication skills—hearing, language, and speech.
3. Psychologic assessment to evaluate mental, emotional, and social development.
4. Sensorimotor assessment.
5. Other diagnostic procedures and examinations to evaluate specific medical conditions, such as heart disease and musculo-skeletal abnormalities.

was recovered from his throat, urine, rectum, eye, spinal fluid, and bone marrow at various times between birth and 1 year of age.

Richard spent almost half of the first year of his life in the hospital, where the hospital costs alone for the first 4 months were \$7,000. He has returned to the hospital as an inpatient three times and has made numerous other outpatient visits. He received special education at the Maryland School for the Blind and is now enrolled in a special day-care center for the retarded, one of several in the Baltimore area.

Richard's mother, who is gentle, concerned, and warm in her relationships with him, has had an extremely difficult time. When Richard was born, his father was in the military service as an enlisted man on overseas duty. Since then the couple has had a little girl, so that now the father is supporting four people with take-home pay from an unskilled

planning for A MASS ATTACK ON RUBELLA

● The imminence of the licensing of a live attenuated vaccine against rubella coupled with predictions of a rubella epidemic possibly beginning in 1970 prompted the convening of three scientific meetings in February and March to prepare for a massive attack against this threat to the well-being of unborn children. The meetings were:

- The International Conference on Rubella Immunization sponsored by the Department of Pediatrics, New York University School of Medicine; the National Institute of Allergy and Infectious Diseases, and Division of Biologics Standards, National Institutes of

Health, held at Bethesda, Md., February 18-20, 1969.

- The meeting of Voluntary Organizations and Professional Societies with staff of the National Communicable Disease Center, held at Atlanta, Ga., February 27, 1969.

- The Sixth Annual Conference on Immunization with National Communicable Disease Center for the Association of State and Territorial Epidemiologists and the Staffs of Immunization Projects, also held at Atlanta, March 10-13, 1969.

The first of these meetings was

chiefly informational. It reviewed developments in knowledge about the disease since 1941, when N. M. Gregg, an Australian ophthalmologist, described the serious effects of the rubella virus on the fetus and newborn infant, especially if maternal infection occurred early in pregnancy, and so shattered the scientific community's complacency about rubella as an innocuous childhood disease. The discussions revealed that in the three decades since 1940, rubella has not only posed unique public health problems, such as how to prevent the spread of the disease by "rubella babies" who may excrete virus for as long as 3 years, but has also raised the kind of medico-legal and religious issues involved in considerations of therapeutic abortion.

In addition to being informational the two meetings at Atlanta were action oriented, with major attention focused on the kind of immunization program that would prevent infection of the fetus in utero, once the vaccine becomes available. Two viewpoints on methods of initiating an attack against rubella emerged:

1. That vaccination efforts be concentrated on reaching all children between 1 year of age and the onset of

6. Careful attention to the social and family implications of raising a handicapped child.

7. Diagnostic summation with recommendations based on the needs and potentialities of the *child as a whole* in relation to the family and the community, including a coordinated plan to meet the child's therapeutic and educational needs.

The findings and recommendations should be discussed with the family in terms that they can understand. Kindness, compassion, and emotional support are essential ingredients in such a conference. The family may need help in learning how to make full use of all appropriate community facilities.

Remedial therapy and special education can do much to improve the functioning of the child handicapped by rubella. The importance of complete evaluation before the child is placed in a remedial or training program cannot be overemphasized. Auditory, visual, or other special training that the child

needs to help him cope with his handicaps should be started as soon as he can be taken about. With special preschool education, many children who have defects from congenital rubella can be successfully prepared for admission to regular school.

Because facilities for special education are few in relation to the many children requiring placement, parents and physicians experience a great deal of frustration. More facilities, more and better trained teachers, and provisions for transporting children between their homes and special education facilities are all sorely needed. Transportation is especially needed for children from poor families.

Risks for the fetus

How likely is a woman who has rubella during pregnancy to have a handicapped child? The answer to this question is still not completely known. Unexplained variations in the severity of fetal infection

puberty, since children, especially those in the early school years, are the major source of infection for susceptible pregnant women.

2. That first priority for rubella vaccination be given to women who have just delivered a baby and next priority to school girls in the 13- to 15-year-old range.

The first method, concentration on the vaccination of children, was recommended by the Public Health Service Advisory Committee on Immunization Practices, and concurred in by the Committee on the Control of Infectious Diseases of the Academy of Pediatrics. The committees would give priority to children in kindergarten and the first few grades of school. They would discourage routine vaccination of women of child-bearing age and would only vaccinate those whose immunity status had been tested and who showed susceptibility to the disease.

Advocates of these proposals pointed out that field trials using the live attenuated rubella vaccine in children have demonstrated its safety, efficacy and almost complete freedom from side effects [See *CHILDREN*, January-February 1969, p. 40], although some

troublesome side effects have occurred when the vaccine has been used in adults, principally transient arthralgia (painful joints) and arthritis. Pointing out that generally by early adulthood serologic evidence of immunity to rubella is present—estimates of immunity being as high as 80 to 90 percent of adults—the vaccination of children was urged as the logical long-range plan for eliminating congenital rubella.

The chief exponent of the second method of attack, giving priority to women of child-bearing age, was a British physician.

Advocates of this method, while agreeing to the importance of vaccinating children, stressed the fact that until the disease is completely eliminated susceptible women should be protected. They pointed out that every year, even when there is no rubella epidemic, some babies are born with malformations because their mothers contracted rubella during pregnancy.

Women being vaccinated, it was pointed out, would have to be warned to take precautions against pregnancy for at least 2 months because of the danger of damage to the fetus from the attenuated virus. They would also have to be warned of the possibility of suffering side effects.

There was complete agreement that pregnant women should not be vaccinated because of possible danger to the fetus. This pointed up the clinical dilemma posed by the pregnant woman who either is exposed to rubella during pregnancy or develops a rash that may be caused by rubella.

Warnings were also issued that while significant progress in reducing congenital rubella could be made with widespread use of the vaccine, difficult problems and questions would remain for future solution. For example:

- Can a further attenuated rubella virus vaccine be prepared which will be effective and yet be free of side effects when administered to adult women?
- Can an attenuated virus vaccine be developed which will not harm the fetus if given to a pregnant woman?
- What is the duration of immunity to the rubella vaccine?
- Is it realistic to expect at some future time the elimination of rubella as a cause of fetal death and congenital defects?

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appear from case to case and from one geographic location to another.

In the Baltimore-Washington area, we have found that more than 50 percent of the women with documented rubella in the first trimester of pregnancy have suffered fetal loss through abortion or stillbirth or have delivered handicapped infants.¹ In our series of 24 women who had clinical rubella between the 14th and 31st week of pregnancy,⁷ there were two fetal losses, seven children who now, at 3 to 4 years of age, still seem normal in all respects; and 15 children with some abnormality. The handicaps of the children whose mothers had rubella in the second or third trimester were not insignificant although not as severe as those of children whose mothers had rubella in the first trimester of pregnancy. For example, 10 of the children had communications problems: six, a significant hearing defect; two, a mild hearing defect, mild mental retardation, and delayed language development; and two, now at the age of 3

still have no useful language, although they seem to have normal hearing and intelligence. Small body size (weight, length, and head circumference at or below the third percentile for race and sex) has been an isolated finding in some infants with congenital rubella acquired after the first trimester of gestation.

Susceptibility

Before the epidemic in 1963, about 80 percent of the women of childbearing age followed in the National Collaborative Perinatal Research Study were found to have antibodies to rubella and thus were not susceptible. Susceptibility rates were higher among Negro than white women (in some areas 50 percent of Negro women were susceptible) and among younger than older women. In 1965, when the survey was repeated, 94 percent of the pregnant women—both Negro and white—were found to be *not* susceptible. Recent studies¹⁸ of innercity residents in

east Baltimore and a cross-section of residents in Frederick County in Maryland suggest that 90 to 95 percent of persons over 15 years of age are no longer at risk of developing rubella. However, another survey indicates that a significantly greater proportion—about 30 percent—of women in California may be susceptible.⁹

Ideally, antibody studies to determine susceptibility to rubella should be done for every woman likely to become pregnant, before the first pregnancy. When a safe, effective rubella vaccine becomes available, susceptible girls and nonpregnant women should be protected by vaccination. As the vaccine presently being considered for licensing is a live virus vaccine and its possible effect on the fetus is unknown, it should not be given to pregnant women.

At present the pregnant woman who is suspected of having rubella, or of being exposed to it, should have serum antibody tests made. Some State health departments and commercial laboratories provide this service. If the tests indicate that rubella infection is present during the early months of pregnancy, particularly during the first 4 months, the risks of fetal death, malformation, and the emotional trauma associated with raising a handicapped child are sufficient to warrant the physician's discussing with the woman and her husband the possibility of terminating the pregnancy, if the law permits this to be done and they desire it.

The injection of a large dose (20 cc.) of gamma globulin into a pregnant woman who has been exposed to rubella has some protective value, but it may merely mask the clinical symptoms of the woman without protecting her fetus. Some infants have been born with congenital rubella although gamma globulin had apparently protected the mother during pregnancy.

⁹ Monif, G. R. G.; Hardy, J. B.; Sever, J. L.: Studies in congenital rubella, Baltimore, 1964-65: Part I. Epidemiologic and virologic. *Bulletin of the Johns Hopkins Hospital*, February 1966.

² Hardy, J. B.; Monif, G. R. G.; Sever, J. L.: Studies in congenital rubella, Baltimore, 1964-65: Part II. Clinical and virologic. *Bulletin of the Johns Hopkins Hospital*, February 1966.

³ Hardy, J. B.: Viruses and the fetus. *Postgraduate Medicine*, January 1968.

⁴ Hardy, J. B.; Sever, J. L.: Indirect inguinal hernia in congenital rubella. *Journal of Pediatrics*, September 1968.

⁵ Bordley, J. E.; Brookhouser, P. E.; Hardy, J. B.; Hardy, W. G.: Prenatal rubella. *Acta Oto-Laryngologica*, July and August 1968.

⁶ McCracken, G. H., Jr.; Hardy, J. B.; Chen, T. C.; Hoffman, L. S.; Gilkeson, M. R.; Sever, J. L.: Serum immunoglobulin levels in newborn infants; II. Survey of cord and followup sera from 123 infants with congenital rubella. *Journal of Pediatrics*, March 1969.

⁷ Hardy, J. B.: Adverse fetal outcome following maternal rubella after the first trimester of pregnancy. *Journal of the American Medical Association*. In press.

⁸ Hardy, J. B.; Sever, J. L.; Gilkeson, M. R.: Declining antibody titer in children with congenital rubella. *Journal of Pediatrics*. In press.

⁹ Sever, J. L.; Hardy, J. B.; Nelson, K. B.; Gilkeson, M. R.: Epidemiological observations of rubella in the Collaborative Perinatal Research Study. Unpublished paper presented at the International Conference on Rubella Immunization, Bethesda, Md. February 18, 1969.

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¹¹ Gregg, N. M.: Further observations on congenital defects in infant following maternal rubella. *Transactions of the Ophthalmological Society of Australia*. 1946.

¹² Swan, C.: Rubella in pregnancy as an aetiological factor in congenital malformation, stillbirth, miscarriage and abortion. *Journal of Obstetrics and Gynaecology of the British Empire*, Part I, 56:341, and Part II, 56:591, 1949.

¹³ Siegel, M.; Greenberg, M.: Fetal death, malformation and prematurity after maternal rubella: results of a prospective study, 1949-1958. *New England Journal of Medicine*, 262:389, 1960.

¹⁴ Lundstrom, R.: Rubella during pregnancy. *Acta Paediatrica*, May 1962.

¹⁵ Manson, M. M.; Logan, W. P. D.; Loy, R. M.: Rubella and other virus infections during pregnancy. Reports on Public Health and Medical Subjects No. 101. Ministry of Health, London, England. 1960.

¹⁶ Weller, T. H.; Neva, F. A.: Propagation in tissue culture of cytopathic agents from patients with rubella-like illness. *Proceedings of the Society for Experimental Biology and Medicine*, October 1962.

¹⁷ Parkman, P. D.; Buescher, E. L.; Artenstein, M. S.: Recovery of rubella virus from Army recruits. *Proceedings of the Society for Experimental Biology and Medicine*, October 1962.

¹⁸ Hardy, J. B.: Unpublished data.

Today's youngster is likely to ask *why* before he says *yes, sir*—and that's the way it ought to be. If, after the *why* is clear and accepted, then, you get a *yes, sir*, it will be one you can count on because it really means something.

Richard T. Frost, Reed College, Portland, Oreg., to the 1968 forum of the National Conference on Social Welfare.

on
being
a
whitey

in the midst of a **RACIAL CRISIS**

RUTH R. MIDDLEMAN

Never before has it been so urgent for the white community to stir itself from lethargy and listen to what black people are saying. I became especially convinced of this during my experience last spring—immediately following the death of Martin Luther King, Jr.—as the only white person in one of the discussion groups for high school students sponsored by the Motivation Program of the Philadelphia Board of Education.

In the shift of middle- and high-income populations from the cities to the suburbs and of vast numbers of poor people from rural areas to the inner parts of our cities, the cities' problems of providing the kind of education their young people need in our changing world have become tremendously complex. Philadelphia's Motivation Program represents an effort to enrich young people's school experience by giving them the kind of personal attention generally missing in the large city high schools of today. I was brought into the program in 1967 to be a discussion leader for groups of high school students. Since I have special training and experience in working with groups, I was asked to be part of a small team of psychologists and social workers who would meet with the students and their parents to consider the normal problems of growing up in today's world.

The Motivation Program seeks to reach its goals of curriculum enrichment, parent involvement, and community participation in school affairs through tutoring, cultural enrichment, and group discussions. One of its major goals is to stimulate high school students to go on to college. To give students and their parents at least superficial familiarity with the "feel" of college life, group discussions are held on the campuses of local universities. Implicit in this approach is the expectation that the students will

come to feel going to college is worthwhile and that their parents will want them to have such an experience. The high schools select students for the program on the basis of their potential for success in college, given sufficient parental support and personal preparation.

The students selected are assigned to a series of seven weekly discussion sessions held on Saturday mornings. Participation is voluntary. The students in each series form a large discussion group, which is divided into four smaller coeducational groups of about 15 students each. White and black students are often deliberately mixed in one small group. For the first and last sessions, parents are invited to join the students in the large group for discussion. Each large group has two discussion leaders, a man and woman, who may also work together in various patterns of collaboration in the small groups.

The program's discussions are focused on the normal experiences and strains that confront high school students in growing up, on the theory that academic achievement is often impeded by dysfunctional relationships outside of school life as well as within it. The discussions deal with attitudes, feelings, and opinions; they challenge students and parents to look at various sides of current problems. Discussion leaders ask the group to consider the consequences of various modes of action. Group members learn how to express their own opinions cogently as well as to respect the opinions of others. Each group, as it is ready, discusses a progression of subjects—understanding oneself, getting along in the family, premarital sex, use of drugs, attitudes toward school and teachers, concern about Vietnam, feelings about one's future in present-day society.

While the leaders help students realize that knowl-

edge of an issue and capacity to look at various sides of a problem contribute to a more adequate approach toward settling differences, they grant that adults do not necessarily possess better answers than young people. They point out that parents—who sometimes feel vexed, troubled, and inadequate—can become less authoritarian in their responses if both parents and children talk out their differences calmly and try to understand each other's point of view. The leaders place themselves in the middle, between students and parents, siding with neither.

The students' enthusiastic response to the group discussions has exceeded expectations. Some students have asked to return for more discussions after their first series has ended; others have stayed through two sessions on the same morning. Many have brought along friends not registered for the program. At times, a student's parents have caught his enthusiasm and have asked if his brother or sister could join the group. Because the program is intended to affect student attitudes, it has acceded to such requests whenever possible.

The program has also had a salutary effect on the morale of many parents. They have raised the same issues discussed in the group sessions with the students and worked on these issues further in the monthly meeting for parents, also sponsored by the Motivation Program.

All told I worked with six discussion groups last year. In the first four groups white students predominated, although each had a few black students. In these groups, while the students were honest in expressing their opinions and often concerned with the problems they had with adults, I found the situation comfortable and never really felt I was under personal attack. One of my techniques in approaching high school students was to look accessible: I wore skirts and sweaters and textured stockings. While I

had no illusions that I looked like a teenager, neither did I look like a professor. I deliberately avoided professional jargon, keeping my vocabulary simple and using the students' idioms.

In the last two groups, I found myself on the spot as a member of a minority race.

Getting with it

In the sixth group, in which the experiences described in this article occurred, all but one of the students were black. For this group I was assigned to work as coleader with Thomas W. Pierce, a psychologist at the Philadelphia Child Guidance Clinic. A black man of great compassion, commitment, and skill, he was greatly admired by the students. Using the students' own language, he employed a simple but psychologically sound approach to group dynamics. His reputation for excitement and honesty had spread throughout the schools. Students clamored to be in his groups. Because he put his stamp of approval on me, I, though white, was tolerated by the students and the discussion flowed freely.

Whether it was Tom Pierce's skill as a group leader or simply the students' need to express dissatisfaction with their hectic, restless style of living, I am not sure, but these discussions were more lively, exciting, and stimulating than any other I had known. At times I could not follow the fast interchanges between students. The special words, meanings, and innuendoes that young black people use when speaking with each other were incomprehensible to me. But most of the time I got the message.

I tried hard to "get with it." In the early sessions I was deliberately confronted with the fact of being different and asked to give my opinion as a white woman on whatever was under discussion. My stance was to be honest and open, and not attempt to try to justify what cannot be justified.

For example, in the second session, Jane, a militant black girl, who was vice president of her almost all-black high school with a great deal of experience in confronting white school administrators, angrily turned on me. Calling me a white liberal, she said she was sick of people like me with good intentions who had really not helped the blacks one whit. I didn't understand, she said, because I had never *lived* in her neighborhood. She said that if I spent a day in her home I would learn something about the noise and crowded conditions that made studying impossible. When she finished talking, the group looked expectantly at me. For a second, I was set back by

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the strength of her argument. Then I answered sharply, "You are doing to me just what you say you don't want whites to do to you. You don't know me and yet you say you know just what my experiences have been. You lump me in with all the whites in your stereotype. I am one person and you haven't talked with me enough yet to know what I feel or what I have experienced!" My indignation had a great impact on Jane and on the group. They settled in to letting me take part in their discussions. Afterward, Mr. Pierce told me he was glad that I spoke with such force.

Although Mr. Pierce and I each had our own style, professional orientation, and separate stereotyped meaning to the students, we developed rapport as leaders and grew to appreciate each other. The searching questions of the students forced us to hold private discussions with each other of our views of life. I was pleased when, at the end of the fifth session, Mr. Pierce invited me to his home to meet his family. In many ways we became closer to each other than either of us did to the students.

Our intense and authentic emotional bond provided a new experience for the students, illustrating what we were talking about when we referred to mutual respect and concern for one another.

Two days following the murder of Martin Luther King, Jr., we had an especially dramatic session, our final one of the series. The whole Nation was still in turmoil, with all of us—adults and young people—stunned by the terror and irrationality of the event. This discussion, a microcosm of the whole world's consternation, affords a view of the attitudes and feelings of young black people at that time. Its value lies in the fact that in the group these attitudes and feelings were *openly and responsibly* expressed.

The following notes on this session were originally made to advise the program's director of my feelings as a group leader about the urgency of providing more young people with such opportunities to express and sort out their feelings if the present chaotic relationships between the races are not to grow worse.

A confrontation

This was the week of our final session when we would meet with students in the morning and then with students and parents in the afternoon for a final summing up of the experience. The one white boy did not show up. Judging by my own apprehensions of what might follow the assassination, I was able to understand why he would stay away.



Some students in the Philadelphia Motivation Program in a discussion with leader Thomas W. Pierce (second from right).

I had telephoned Tom Pierce the day after the assassination to sort out my feelings about it and let him know how I felt. Mr. Pierce, although stunned by the news, had spent the day trying to help elementary school students in their shock. He said I just *had* to attend our discussion group the next day. I replied that I had never questioned this because I knew that I could not do anything *but* come. What I could possibly say that would have any meaning was another problem. Our conversation generally reassured us that we were together in feeling, just as we had been throughout our earlier discussions.

I mulled over the situation on my way to the university on Saturday morning. I knew that by now I had established a fairly good rapport with the students. They had expressed many doubts and much anger toward white people because of their less-than-equal opportunities in school and work. I knew they considered me honest and regarded me as a person who would accept without retaliation, explanation, or justification their resentments against the world as they found it and against white people in particular. I must admit I was scared, but I counted on the students' general liking for me, even though I was white, and my previous fairness in considering problems.

When Mr. Pierce and I entered the room, we found a girl waiting for us. Her first comment was that one of us better write her a note to take home, because her mother would not believe that our group would really be meeting this day and would wonder where she had been. Mr. Pierce said he would do better than that; he would telephone her mother and try to get her to come to the afternoon session. While he was

gone, several other students arrived, tense and expectant. I wanted to delay starting the discussion until Mr. Pierce returned so I could have his support. But this was not to be.

Jimmy began it by directing a burning question to me as soon as he entered the room. He went right to the point. He talked about being a track star, knowing many white people all his life, liking some of them, and being taught that he should try to like them. But now how could he? He said he was utterly confused. All he could feel was anger and rage against *all* white people for what had happened. He didn't know how he could ever get over such feelings. Finally he wanted to know what I had to tell him about THIS!

So there, out in the open, was the theme that was to consume our energies for the next several hours. In response to Jimmy I told about my telephone call to Mr. Pierce the day before, my own shock and horror, my understanding of why he might feel such hatred, and why I had no pat answer on how he could feel otherwise. A terrible thing *had* happened. I said I didn't intend to try to talk him out of his anger. But I wanted him to notice that I was *here* this day to talk with the students, to look together with them at how we all felt, and most of all to keep communication open between us. This, I said, was what we had to do this day. I hoped that people everywhere would be able to do the same.

Violent reactions

The precise exchanges in this meeting are impossible to report verbatim. We were so involved that it is hard to remember everything that was said. The students were full of feeling—hate, giving up on white people, hopelessness, the futility of Dr. King's nonviolent approach. To them what happened confirmed the argument that the nonviolence was "way off" as a solution to their problems. They expressed impatience, cynicism, and pessimism.

At one point, Michael turned to me and announced, "If I were you, I would be home hiding under my bed right now." According to the students, the black revolution would come whether or not they, or we adults, wished it.

I was glad when Mr. Pierce returned. As in previous sessions, he personalized the dilemma of black and white by using the relationship between himself and me as an example. He asked the students what he should do if he were walking down the street with me and some black people he did not know tried

to "grease" me. Should he ditch me or go down with me? The students said he should ditch me, that he would be left stranded if he took any other course of action. I would never take *him* home to *my* house, they said. Although I protested that I do have black friends of mine come to my house they did not seem to believe me because they did not know any black people who had ever been invited to a white person's home.

Mr. Pierce, with great emotion, tried to get each student to consider how he would react in this situation with a white friend. But most of the student had no white friends so they could not relate to the problem. One or two said they did have a white friend, but added, "No, I would not stand up for him." However, their tone and facial expression indicated that they were undergoing great emotional confusion and that turning their backs on their white friends would not be easy.

Mr. Pierce carried most of the discussion while I responded here and there, serving mainly as a target for the students' bitterness. He tried to get across to them that rioting and self-destruction were not a wise course of action for black people. Adult arguments—his, mine, and later the parents'—fell on deaf ears. I found myself utterly frustrated because the young people seemed so set in their attitudes. They kept telling us of how long black people had been persecuted, and of how little our ways and thinking had helped the world. They pointed out that we of the older generation just could not possibly understand how they felt. They said that they did not care whether horrible destruction and death for white and black alike occurred if eventually things would be better than they were now.

At one point, Mr. Pierce tried some role playing. He asked each student in turn to "think white" and me to "think black." This put the students under a terrific strain. At first they said they could not possibly do this, but he persisted. Finally one after another the students made some hesitating attempts to mouth the stereotyped attitudes of white people about black people. Then the idea caught on and the role-playing became easier for them. I did my best to express black anger. The students shifted for a few minutes into conversing among themselves, pretending they were white people and joking and hooting at what was said. Finally, Robin said softly, "I pity the white people; they must feel awfully bad right now." Her sentiments were not shared by the others, but were met by bitter laughter.

The group was still upset and angry when at noon we moved to a larger room for an afternoon session with parents and other students. I was spent from the intensity of the morning's experience, so I left to get sandwiches for Tom and myself. He stayed with the students.

While I was in the cafeteria, Jimmy came up to help me carry the sandwiches. He said awkwardly, "I hope you can understand why I had to say what I did to you this morning. I do think you're a pretty nice person and I don't like to think of your being killed, but I just have to feel this way and will have to be part of it if it happens." I was very touched. I told him that I understood and still thought he was a nice person. I added that I had two teenage boys of my own and hoped to live long enough to see them grown, but if I had to die, then I was ready to do so.

Change in tone

The afternoon session had a slightly different tone. We were joined by parents, discussion leaders, and students from two other groups. There were two black students—one very vocal girl and one boy—who spoke against violence as a solution. In spite of being jumped upon by most of the others, the girl stood her ground. After listening quietly for about half an hour, a 40-year-old father made an impassioned plea for restraint. He told the group he had dropped out of high school but had returned as an adult and had received his diploma only a year ago. He tried to impress upon the young people that advancement was possible, despite all they said about the inferior quality of education in their schools, if they would stick with it and make the most of their opportunities. His opinions seemed to fall on deaf ears.

A mother told of visiting a junior high school where she observed what she described as wonderful training opportunities "better than Bok Vocational High School"—the students learning to make beds, do tailoring, and master other practical skills. She quoted the black principal as saying that the school had obtained the program because the parents had spoken up through their community group. Our students dismissed the training program she described by saying that the white schools got all the good things.

Near the end of the meeting, I said that I had been listening to their message—that they had been telling me all day what I should go and tell my white friends. Now I had a message for them, my black friends.

I said the young people who were at the sessions without their parents should go home and tell their parents what we had talked about today, trying to get their parents interested and active in the schools. I spoke of school improvement being achieved, not on a racial basis, but on the basis of pressure from parents who spoke up for what they wanted their children to have. When some students talked about their parents' not knowing how to speak up, I urged them to help their parents to do so. I also spoke of how such things as the Motivation Program helped to correct the balance a bit.

I left feeling wrung out. I was sick all over—headache, stomach ache, and mainly heartache. In my 25 years of working with groups, this had been the most intense, difficult session I had ever experienced. It called on everything I had as an adult white member of our society—and found me wanting. As I thought about all that had been expressed this day, it did not seem to me that the students had changed much, unless being together and ventilating all that feeling had somehow helped to relieve the strain on them. Still, they had been frank; we had heard them and expressed our adult values. Perhaps in their confusion they might remember something we had said about how much we valued them.

Not long ago, I had a telephone chat with Tom Pierce, who told me two things of interest. He had invited all students in the group to a meeting the week following our discussion and many had come. At this meeting the intensity of the anger had diminished somewhat. The students talked much about how they would carry on, what college life would be like, and how they might try to get along with others in new situations. Jimmy, who still dropped by to see him from time to time, had decided to go to college instead of becoming a tailor. On one visit, Jimmy had asked how I was.

The lesson

What is to be done next? Surely more and more such approaches at communication must take place to help young people gain a sense of their own self-worth and of their worth to the larger community. The separation that exists between black students and white students is the shocking reality of our day. There can be no change of attitude, let alone change of behavior, while the black students cannot even call to mind one white friend. The foregoing experience was limited in its usefulness in bringing the races together in that all but one of the participants

were black. For some of the students, having a frank discussion with even one "whitey" was a new experience.

Many months have passed since I had this experience. Much has happened and much has not happened. I find myself still hearing the students tell me, "Tell THIS to your white friends . . ." And I find myself remembering other parts of that discussion:

"We're sick of hearing that prejudice is a disease and that we have to understand that. We don't care that the white man has this problem."

"When the next riots happen, they're not going to be in our neighborhood but in yours."

I can remember the students' lack of concern when I described my own experience with prejudice as a Jew as I grew up. From their point of view, it was irrelevant that I had trouble getting a first job. One student noted that prejudice had not kept me from knowing since childhood that I would get to college. It had not made dropping out or giving up part of my family's culture or of my friends' experience. All I had to do was make some practical choice and continue to pursue my essentially self-confident course. In one fell swoop, a longheld and slightly self-pitying memory had been debunked.

I can also remember, with horror, how calmly the students discussed the knife fights in their schools; how vividly they talked about what they would do in a riot—they had all been part of little pieces of such conflict already; how unconcerned they were when I mentioned that my son had, without provocation, been hit in the stomach by a black friend the day after the assassination. I can hear the students tell me that we "whiteys" just do not understand that they see things differently than we do.

In retrospect, it seems to me that the soundest part of the experience was not what we had talked about but how the discussion had been led. A white woman and a black man talked back and forth with each other, as well as with the group, sharing a piece of their own lives and accepting each other's differences. The students might remember this more than our most cherished opinions and philosophies. Did this kind of leadership help them see a possibility of a fruitful exchange between blacks and whites?

I had this experience not simply because of my own skill in group discussions. I could have met with the black students for months and never been part of such intimacy. Partly, I rode along on the rapport developed by Thomas Pierce. I was in the group while the members "leveled" with someone they deeply trusted. He helped them to permit me to participate in their thinking. Partly, it happened because of their shock at losing a great hero.

I know now that this experience has probably altered my life far more than it did theirs. For I am one "whitey" who had the good fortune to see and hear "how it is." Can I possibly transmit this well enough to white people to increase their understanding in time to avoid the kind of holocaust the black students talked about so vividly and with such certainty? Can other white adults possibly learn to change their views of life, reassess their opinions of why and how things are as they are, and learn to listen? Can I myself learn to hear properly?

I am still carrying the students' message—their warnings, their desperate urgency, their volatile reactions, and their faint hopes for orderly change—to "my white friends" on every occasion I find. And I have found many occasions: a program in the auditorium of a prestigious suburban private school; the annual meeting of the board of the local Boys Club; and my own classes at the University of Pennsylvania.

I know that I am teaching differently now. For I have seen at close range that much that I had once believed about race relations is simply not useful today. I have been working with a racially integrated faculty to prepare for the opening of Temple University's new Graduate School of Social Administration in the fall of 1969. One of our major aims is to bring black graduate students and white graduate students together to work on problems of the urban ghetto.

I believe that the central educational objective of the schools now must be to teach students to live with change and be ready to solve new problems. And this kind of life approach must be taught by adults who are able to accept new patterns and ideas and who have poise and resilience. The first necessity is to learn to hear!

AGGRESSIVE GROUP WORK with TEENAGE DELINQUENT BOYS

HARRY E. GROB, JR.
ERIC E. VAN DOREN

● "What sort of stinkin' mess have we got ourselves into?" we asked each other. It was beastly hot, we were tired and sore. We were asking each other for encouragement to go ahead with the project.

As program director and social worker at Chaddock Boys School, Quincy, Ill., a private institution for teenage delinquent boys, we had begun extensive planning many months before for a wholesome summer program for the boys. Study groups, seminars, various committees, and endless staff discussions had been used in an effort to develop something worthwhile. By late spring, we had thought we had a well-planned, constructive summer program.

An unforeseen hitch had developed. The institution was faced with a shortage of relief houseparents that seemed likely to continue until fall. This meant that the regular houseparents would have no time off and so could not be expected to add participation in the summer program to their duties. Therefore we created the Valley Project to (1) provide a substitute summer program; (2) reduce pressure on houseparents; (3) demonstrate to the staff some of the principles in-

involved in work with delinquent boys; (4) offer the boys added group experience; ¹ (5) learn more about teenage delinquent boys; and (6) help with community relations by clearing up an unsightly section of the campus.

We had our plan and knew the direction we wanted to take. The idea was to clear and beautify a swampy, brush-covered valley that had not been cleared for at least 35 years. Dead trees were to be cut down, their stumps completely removed; buck brush, grapevines, and weeds were to be cut and burned; junk and trash were to be pulled and sludged from the bottom muck; razor-edged swamp grass was to be hacked out. The entire area was to be raked, mowed, and reraked. The snake, rat, and mosquito infested swampy "jungle" was to become an open valley graced by "home grown" seedling trees and a clear, running stream fed by its natural spring.

Covered with blisters and beads of sweat after our first couple of hours of looking the area over and hacking a few weeds, we already began to look to each other for support.

The two of us spent approximately 150 hours working side by side with the boys as we supervised the project. Three mornings a week for 3 months we took one or two groups of boys to the area to be cleared, alternating the groups so that every boy at Chaddock participated in the project. A work group usually consisted of all the residents of one cottage—about 10 boys. Each work session normally lasted between 4 and 5 hours.

We kept the rest of the staff informed of our plans, our progress, and the principles involved.

Focus on principles

By agreement, the cottage staff members evaluated our work with the boys. We had daily sessions with the houseparents of each cottage and monthly group sessions with the entire child-care staff. In these meetings, the attention was focused on the principles we were trying to demonstrate and the effect they had on the boys. Undoubtedly the discussions were affected by the fact that the staff members were fully aware of the adverse conditions under which we were attempting to demonstrate these principles, for we came to the meetings straight from the valley in our sweaty T-shirts, with scorched, infected skin and bleeding, blistered hands.

One principle we wanted to demonstrate was that the boys would be encouraged to cooperate if they had (1) a choice in whether or not to participate in the

project, (2) an opportunity to help formulate the goals, and (3) a clear understanding of the goals.

Before each work session, we would assemble in the shade of an oak tree overlooking the valley. A warmup talk was usually initiated by one of the boys and concerned the progress of the work project. After the talk, we gave each boy in the group an opportunity to speak up if he did not want to work that morning. Any boys who declined to work were allowed to sit on the bank and watch the rest of us work. Invariably these boys soon joined the group of their own free will. For example, there was Charles, a defiant boy who usually managed to maneuver adults into a power struggle and who was sometimes downright frightening with his threats and potential for violence.

"You ain't making me do any work," Charles growled one morning. While the rest of us started to work, he remained seated under the oak tree. Soon, however, he sauntered up to the program director.

"Ain't you gonna make me work?" he asked.

"Nope," was the response.

Mumbling, "The man must be crazy," Charles began to work.

Charles continued to test us with his defiance. We always responded in a way to convey: "If you want to help, fine; if not, we still like you." Eventually, during his individual counseling sessions with the social worker, Charles began to seek an understanding of his experiences in the valley and what they had taught him about "how to get along with people who treat you right."

We encouraged the boys to adopt the slogan, "Understand the deal before you start working." In the early days of the project, we outlined the general goal for the morning as well as each boy's assignment. We made sketches in the dirt, told them what needed to be done, and demonstrated how to do it. We gave the boys ample opportunity to ask questions. We also asked each other about unclear points to help the boys see the usefulness of asking questions about what they did not understand.

If a boy seemed not to understand his assignment clearly after we began work, we reassembled the group at the oak tree. The problem was mentioned. We emphasized the group's responsibility for seeing that its members carried out their assignments. It did not take long for the boys to sense when a youngster was "putting on" and to advise him, "If you don't want to work, you know you don't have to, but if you do, then get with it." When a boy actually did not understand his assignment, the other boys helped

him but also reminded him to "speak up next time."

While in the beginning, by design, we presented boys with the familiar situation of adults doing the deciding, gradually we encouraged the boys to formulate the work goals themselves. We did this by challenging them to participate in our discussion of what should be done that day: "We want the babies among you to sit, listen, sulk, and stew. We want the men-to-be to speak up. If there's no talking, then we'll have to do the planning for you."

For several sessions the boys tested our sincerity in making this challenge. At times they would just sit, and at times they would give extreme and obviously unreasonable suggestions. Gradually they seemed to sense our conviction that a group is obligated to participate in working out its own destiny. The briefing sessions under the oak tree underwent a change. Without being asked, the boys indicated their willingness to work. We designated the area in the valley where work would be done that morning and then encouraged the boys to discuss what kind of work to do and who was to do what part of it.

Staff reaction

Generally, the houseparents responded positively to our efforts to encourage the boys to cooperate. The boys' happy spirits as they returned to their cottages caused a great deal of comment. A typical houseparent reaction was to ask, "How can the kids be so darned happy after working down there in 100-degree heat, pouring rain, and everything else?" Our response to such a question was to invite the houseparent to come down to the valley and see for himself. Observing the work, a housefather remarked, "It shows that kids will help on even the grimmest jobs and be happy—if they're treated like human beings."

The houseparents also noted that the boys were showing greater willingness to participate in working toward various cottage goals and were doing so more constructively. The houseparents themselves showed more awareness of the resentment that young people, as human beings, feel about their lack of voice in their own destiny.

One housemother, for example, after writing a thank-you note to a person who had sent a gift to the cottage, assembled the boys and asked them, as she usually did on such occasions, to sign their names. She was met with silence. She then thought of the valley project and asked the boys how they would rather handle the matter. The general response was, "Whatever you say, Mom." But she persisted in ask-

Harry E. Grob, Jr. (left), and Eric E. VanDoren report here on their experience in a summer program for juvenile delinquents while working as program director and social worker respectively at the Chaddock Boys School in Quincy, Ill. Mr. Grob is now chief of social services and Mr. VanDoren is a supervising social worker at the Illinois State Training School for Girls, Geneva. Mr. Grob received his master's degree in social work from Washington University, St. Louis, Mo.; Mr. VanDoren, from Missouri University, Columbia, Mo.



ing for the group's ideas saying, "I'm just thinking that it really isn't fair to ask you to sign something you didn't write."

As a result of her persistence a number of ideas were forthcoming: letting one of the boys who aspired to be an author write the letter; having only those boys sign it that wished to do so; having the letter delivered by a small committee of boys accompanied by the housemother. The housemother agreed to this procedure. Afterward she worked with the cottage group toward other goals in the same way.

In discussing our work with the staff, we told of our failures as well as our successes.

We had erred, for example, in handling Jim, a bright lad who had been pushed around so much in his 16 years that he was not about to hurry for anybody. During one work session Jim tested our work-at-your-own-pace policy by loitering on the job. We scolded him for not having told us sooner that he did not want to work that day, and as a result he spent the next two work sessions just sitting on the bank staring at us. We had erred too in dealing with Douglas. A new boy who had arrived at the institution the day before, Douglas had not had time to catch the drift of the project. We were particularly tired and hot that day. When Douglas began to question the value of the project and why he had to participate in it, we responded, "If you don't want to participate then just go on back home." He did—several States away.

In discussing these incidents with the staff, a housefather remarked, "You know, I've run boys off, in one sense or another, in both those ways too. As I look back on it, each time the boys didn't really feel a part of things."

As a whole the cottage staff had two major ques-

tions about the advisability of encouraging the boys to cooperate voluntarily. First, they asked whether the boys wouldn't take over the institution if they were permitted "a say." In answer to this, we challenged staff members to give us an example of a situation in which any such attempt had occurred because boys had been given a chance to exercise initiative. One staff member offered two examples of "boys getting out of control." We asked that these examples be analyzed in a staff group discussion. In this discussion an observant housemother pointed out that the principles involved in encouraging voluntary action *had not* been applied in either situation; that, in fact, the boys complained of had been permitted simply to "run loose." The complaining staff member acknowledged that in both examples such undirected permissiveness had been allowed "just to see what the boys would do."

The second question had to do with the belief held by some members of the staff that "boys learn by being made to do." We praised these staff members for expressing their opinions and did not argue their point. However, we expressed our belief that boys must learn to deal with reality, and that reality should not be composed exclusively of "having to do." Probably we did not change anybody's point of view at that time, but perhaps we helped some staff members think about alternatives to their own viewpoint.

Encouraging ideas

The Valley Project offered us an opportunity to demonstrate the effectiveness of certain conditions in encouraging creativity. As a result, the boys barraged us with ideas that came out of their own thinking.

Years of being expected only "to speak when spoken to" or of thinking only in terms of "keeping ahead of the rat race" had failed to nurture the potential for creativity in these boys. Yet, we believed, buried somewhere in their defensive, scrambled thoughts were creative ideas. We believed that the necessary conditions for bringing these ideas to the surface were for the boys to settle down enough to think logically, to feel that the request for them to contribute ideas was sincere, and to be willing to face reality.

We also believed that when a boy is constantly under fire he cannot be creative. He cannot produce ideas under the kind of stress that comes from harassment, ridicule, or always having someone on his back. In the valley we tried to reduce this kind of stress. We would not let a boy begin working if he

was markedly upset and we would not let a boy continue working if he became seriously upset on the job. We allowed good-humored joking and kidding but not meanness or ridicule. We attempted to show the boys that we sincerely wanted their ideas. We included them in decisions, discussions, and small talk.

The response to our request for ideas from the boys sometimes had both immediate and continuing results. It did, for example, with Albert, who was caught in a cycle of being frequently picked on by the other boys and reacting with behavior that drew further criticism from them. When we asked Albert to help us find a way of keeping the water away from the muddy low spots in the valley, he suggested a plan for draining the water through channels rather than trying to hold the water back through dams. The plan worked, and we continued to encourage Albert to present ideas born of his engineering talent. The pressure of criticism on Albert diminished, and he became more at ease and more a part of the group.

We tried to take advantage of as many sparks of interest as we could. The phenomena of nature helped. The boys began to show interest in the birds, trees, and wildlife. They began to ask questions: "Why do we only hear certain birds early in the morning when we begin work and not later in the day?" "Would it be okay if we caught a sample of each kind of bug that bit us to take to school?" "Can we send some of these weeds someplace to find out what kind they are?" Out of such interest flowed ideas.

The necessity of facing reality also helped. Each boy had to make a choice: "Is it fun and games forever or do I really want to grow?"

Each boy had to decide whether he really wanted to be a part of the working group. It was usually obvious to everyone which boys wanted to be a part and which ones did not. Fred tried to fool himself as well as others, by acting as though he were busy and claiming most of the credit, although actually doing little work. One day another boy, Robert, confronted him: "Look, Fred, the world just ain't this way. The only thing you're doing is looking for whatever you think you might get out of it. I feel sorry for you, Fred, because things just don't happen your way."

As the project progressed, most of the cottage parents increased their efforts to encourage the boys' ideas. Boys would return to their cottages and tell the houseparents about the suggestions they had made during the work session in the valley. Often they were met with such comments as, "That sounds good, perhaps we can use that idea here too."

A few staff members were worried that we might be

letting the boys tell us what to do. They said they always knew that the boys had a lot of their own ideas that they just weren't mentioning and asked us whether we weren't encouraging them to start telling us how to run things. Sensing this attitude in a staff member, one of the boys told him, "I know you don't want my ideas on things; that's why when you ask me what's wrong today I don't ever tell you."

Stumping the slump

About halfway through the project, we felt a need for a "picker-upper." We noted some restlessness and a drop of enthusiasm among the boys. We were tiring some ourselves. To help counter this slump, we challenged the boys to a stump removal contest. We talked to each cottage group separately, presented our plan, and asked for and got the ideas from the boys.

We divided the valley into four areas, one for each cottage. A rough count of tree stumps came to about 250. Walking through the areas with the boys, we pointed out that each area contained over 60 stumps that needed to be removed before it could be mowed and the project considered completed. We told them that for the contest the circumference at the base of each stump would be measured and each cottage group's entry would consist of the total measurement of the stumps removed by the group. The judges would be the academic tutor and the cottage housefathers.

One especially cooperative group of boys asked what they could do if when they finished removing all the stumps in their areas, some stumps still remained in other areas. All of the groups agreed that if a group finished removing the stumps in its area, then the stumps in other areas were "fair game."

The stump project changed the way some boys were regarded by others. One boy whose image in the group improved was Dean, whom the boys had disparagingly called "Miss Dean." When he had entered the institution several months before, he had brought along a huge box of "comics," a supply of corn plasters, bubble bath, hand lotion, a large supply of handkerchiefs, and assorted pills and prescriptions.

We learned that besides carrying around several "hankies," Dean carried a keen sense of curiosity. Finding him standing alone in the rain one day, the social worker asked what was bothering him. He said he was wondering "why some kinds of stumps were so much harder to get out than others—maybe

it was the difference in root structure." Another boy, who had sauntered up just at this point, laughingly suggested that Dean find the toughest stump he could and spend the next couple of years trying to remove it. The social worker, however, encouraged Dean's intellectual approach to the problem, and for almost 2 hours the boy experimented in the rain, developing techniques for removing different kinds of stumps in different ways.

When he returned to his cottage soaked with rain, mud, and sweat, and wearing an unaccustomed expression of happiness, Dean was almost unrecognizable. He had even devised a way to use some of his handkerchiefs as markers for the tap roots. The boys in his cottage became interested in his findings, and together the group worked out teams for special types of stumps.

Health and safety

We wanted to demonstrate to the boys the importance of taking health and safety precautions in their daily activities and how to do it.

At each briefing session for the first few weeks of the Valley Project, we explained to the boys the function, use, and care of the basic tools used in the work and the safety precautions they required. After a while we found that each boy tended to select one particular tool as his specialty. We encouraged this

tendency and tried to help each boy recognize the dangers of handling the tool he had selected and the safest way of using it.

Ross, for example, had used different kinds of tools but had shown little interest in any of them. Then, one day on the way to work in the valley, he asked to use a grass whip. Of all the tools available, we thought, Ross, a real "swinger," *would* have to choose the most dangerous tool we had!

Realizing that Ross was testing us, we reminded ourselves of our agreement to encourage boys to develop special skills with the tools of their own choosing. We gave him a chance. When the work session began, we called him aside and explained how to use the tool properly and safely. After he began using it, we needed to remind him a few times of some safety points, but on the whole he was careful and did a good job. Afterward, whenever we asked Ross to clear a designated area with the grass whip, he tried carefully to use the tool safely.

Many of the boys had accidents because they did not understand how to work with tools, had little or no experience in working around others, or were trying to attract attention. For some time the boys had to remind each other about simple carelessness and failing to remember that others were close by.

Elmo was one boy who had to be watched because of his need for attention. Just as somebody was beginning a backswing with a sickle, Elmo would walk

Before and after in the valley. Left, a neighbor youngster comes to see progress shortly after the boys began to clear one of the sections. Right, the stakes show where some of the stumps were removed from a section of the valley just about completed.



behind him, or just as somebody was about to chop at something with an axe, Elmo would reach down in front of him to pull out a weed.

Randy was another boy who seemed to invite accidents. In the first hour of one work session, Randy managed to cut his finger, drop a heavy branch on his foot, and burn his hand. Finally another boy said to him, "Look, Randy, you don't need to do all of that; they already told us if we didn't want to work or be a part of the group to just go sit down."

We also pointed out the need to take special precautions against heat exhaustion, such as adding salt to the diet and stopping to rest when overheated. In addition, we stressed certain basic rules of good hygiene, such as frequent bathing. In the beginning, the boys often griped about the heat or the cold, depending on the kind of day it was, but as their interest in what they were doing grew and as they saw the two of us working beside them and asking no more from them than from ourselves, they complained less and less about the usually adverse working conditions. They became able to pace themselves and avoid such heat reactions as rashes and skin infections.

Sam was one of the exceptions. A frail lad whose hobbies were reading and watching TV, Sam received a few chigger bites that conveniently became infected from his constant scratching, picking, and failure to bathe. He informed us that his houseparents told him that he had to stay indoors, and he told his houseparents that we did not want him working in "that condition." Together with the houseparents, we consulted the staff physician, who prescribed medication, daily bathing, and "plenty of outdoor exercise." Later Sam began talking with us about his difficulty in working with, or even being with, other people.

Telling the world

From the beginning we tried to keep others informed of the progress in the valley. We developed a followup system for letting the cottage groups know what was taking place. As long as we took the initiative, it worked fine; but when we stopped taking the initiative, the boys stopped being inquisitive. We tried to point out that communication is a two-way street—if you want to know something and you are not told, then ask.

We tested the effects of regular communication by choosing one cottage and keeping the boys in that cottage up on things. We answered all their questions

about the project, held special sessions with them before and after each work period and during the breaks, and explained any special points regarding their part in the project. In the other three cottages, we only responded to questions asked us and took no initiative in giving out information. There was a noticeable drop in the morale of boys in these three cottages.

We kept the outside community informed too. Reactions to the project varied. The comments of our surrounding neighbors, for example, were of two kinds: (1) "The project has purpose—It's good to see somebody doing something constructive with kids"; and (2) "It's good to see the neighborhood shaping up."

We also kept the local police informed about the project. Before it began, the police had told us in a friendly way that the valley had in the past been used by lawbreakers as a place to store loot. Now members of the police force often visited the valley in their off-duty hours to see how the project was progressing. Some of the boys registered surprise at the interest the police showed in their work.

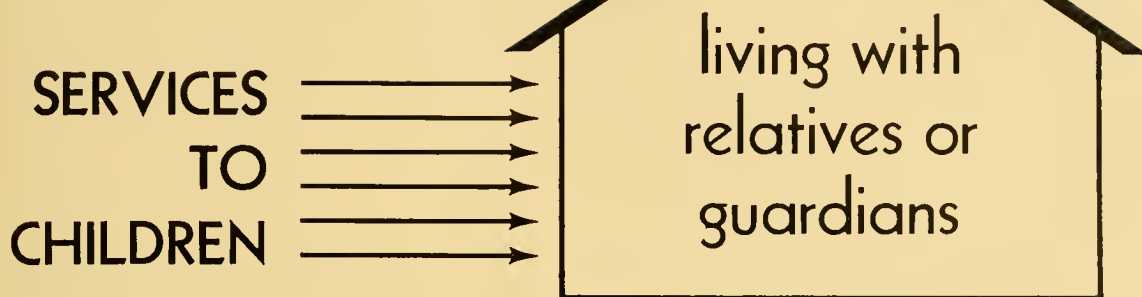
We, the project initiators, in a sense also kept each other informed. In the beginning we had agreed to keep an eye on each other, and we did. We told each other of any trends or feelings we had noted. We would watch the other fellow and let him know if he seemed to be angry or extra tired and so susceptible to a boy's baiting or provoking.

MANY PEOPLE like to work and work hard. So, in that respect, we did not do anything special. Group work with delinquent boys is not new. Lots of people talk with groups of teenage delinquent boys. So did we. Our experience, however, has convinced us that *doing with*, in addition to talking with, teenage delinquent boys makes it possible to demonstrate the principles being talked about and so adds an exciting, practical, and useful dimension to group work with delinquent boys.

We especially felt this during the valley dedication ceremony. The planning, preparation, and implementation of the ceremony were all a joint staff-boys undertaking. Watching and listening to the boys conduct the ceremony and tell "how it was" in the valley, we who worked with them felt that many of the boys were, in different ways, talking about many "valleys" they had been working to clear up.

¹ Grob, H. E., Jr.; VanDoren, E. E.: Debating in a treatment program for delinquent boys. *Journal of Correctional Education*, Fall 1968.

how public welfare workers
in a Maryland county
provide . . .



SHIRLEY L. HUGHES

● In its first year of providing a special casework service for children who are receiving public assistance while living away from their parents with relatives or legal guardians, the Baltimore County Department of Social Services has found that many such children need special attention to protect them from situations detrimental to their healthy development. The agency has also found that through intensive casework service some of these children can be restored to their own families.

In Maryland, State and Federal funds may be used to support needy children who are living with relatives other than their parents, and local funds may be used to support needy children living with nonrelated persons appointed by the court as their guardians. In both circumstances, the adult caretakers have no legal obligation to support the child, but they must have sufficient independent means to support their own families. Such cases account for about one-fifth of Baltimore County's total caseload of children receiving public assistance. The children have been separated from their parents either through a private arrangement between the parents and the person providing care or through court proceedings in which a legal guardian was appointed for a child, a relative was given custody, or the child was committed to the care of the Department of Social Services.

For many years the Department had little opportunity to give a careful look at what was happening

to such children. The workers carried such big caseloads that their service efforts were usually confined to intervening in crises that threatened to break up families. Because emergencies, such as evictions or threatened evictions, occurred daily, the workers tended to overlook cases in which the children were living in homes of self-supporting relatives and guardians and to assume that the caretakers would phone the agency if serious problems arose.

The passage of the 1962 amendments to the Social Security Act provided an opportunity to examine these cases more closely, for they increased the rate of Federal reimbursement for the cost of services to families in the program of aid to families with dependent children (AFDC) and encouraged the reduction of workers' caseloads to a manageable size. When the Department's caseloads were accordingly reduced, the workers were asked to review all their cases to determine the service needs. The ensuing careful evaluation of all public assistance cases involving children resulted in the decision to assign some workers to caseloads consisting entirely of children living with relatives and guardians, and to give a specialized service to these children and their families.

The first step in providing services to such children was to pull their cases together into two special caseloads. Previously, such cases had been assigned geographically, which meant they had been scattered

among the various workers. To give the workers a chance to attend carefully to each case and to learn more about the kinds of problems involved, the agency began by assigning only 35 such cases to each special caseload rather than reassigning all such cases at once. However, these special caseloads were soon increased to 61 and 58 cases, respectively, and 20 other such cases were assigned to a worker whose caseload also included 35 AFDC cases of children living with at least one of their own parents. Several other cases of children living with relatives or guardians are still scattered among workers in the AFDC program but will eventually be transferred to special caseloads.

At present, the agency's assistance rolls include about 160 active cases of children living with relatives or guardians, of which 139 are assigned to the special caseloads. Children placed independently by their parents, many of them at birth, account for the majority of children in these special caseloads. In most cases, the caretakers have applied for assistance only when a financial crisis has occurred in their own families. For children placed as a result of court action, assistance has usually been requested at the time of placement or shortly thereafter.

The service plan

Behind the creation of these special caseloads was a plan to give intensive service, as needed, to each child, the relative or guardian caring for him, and to the child's natural parents. The workers were asked to attend to problems of child development, family functioning—both in the caretaker's family and the child's own family—the relationships between parent and child and caretaker and child, abnormal behavior, and the child's reaction to separation from his parents. These are much the same problems that the agency has long recognized as affecting children in foster care.

The hope was that in many cases the worker could help the child's parents change their situation enough to enable the child to return to live with them. There was also the hope that in some cases the worker could effect a more favorable environment for the child while away from his parents by helping the relative or guardian gain a better understanding of the child and his problems, more acceptance of the child's parents, and enough security in his own role to relax his need to "replace" them. The workers were expected to spend more effort on direct service to the child than is usual in the AFDC program on the theory that the establishment of a close working re-

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lationship between worker and child would reduce the emotional conflicts that beset the child who is separated from his own family.

The agency's services to the families and children in these cases begin when the child's caretaker first comes to apply for financial assistance for him. The intake worker discusses the child's situation with the applicant, makes a preliminary evaluation of the problems that might exist within the family group and carries out whatever immediate services seem appropriate. The intake worker also describes the services the applicant can expect from the agency and tells him that a worker will be assigned to work both with his family and with the child's parents, with the possibility in view of arranging for regular visits to the child of his parents and perhaps of eventual restoration of the child to his own home.

In several months of concentrated attention to these cases, the agency has learned many things it did not expect. It discovered that the problems in many of these cases were very serious and that many of the children were living in unsuitable situations. It discovered characteristics of these cases that had not been apparent when they had been scattered in undifferentiated caseloads. It found that grouping these cases together into special caseloads created the climate for a much better evaluation by enabling the workers to see their common qualities.

The agency's efforts to involve the children's own parents in the children's lives have generally been very rewarding. The workers have found that many of these parents are interested in their children, want to see them regularly, and have hopes of reestablishing a home for them. In some cases the children's parents have been maintaining contact with their children all along. However, in a relatively large number of cases, the parents have lost touch with their children—often because of guilt feelings or dis-

sension between the parents and the caretaker—but are usually very receptive to the agency's offer of help in reestablishing their family relationships.

Feeling alone in a hostile world, many parents have despaired of being able to establish a suitable home for their absent child or children. Insecure, disorganized, problem-ridden, and poverty-stricken, they present a disadvantageous contrast to the seemingly secure, stable, and financially successful relative or guardian. Therefore, when the agency shows concern for them, belief in their potential strength as parents, and interest in helping them improve their situation, they begin to see some hope of being able to change their situation and eventually to have their children returned to them.

When "intensive service" is applied, the worker has weekly contacts with the child, his parent or parents, or his caretaker and then tapers off to monthly contacts as the child's situation improves. During 1968, 15 cases received this type of service, resulting in the restoration of six children to the homes of their own parents.

Unsuitable homes

In each of the 139 cases in the special caseloads, the workers have spent considerable time in determining whether intensive service is needed, through visits with the child, his parents, and his relative or guardian. They have found in 65 cases, or nearly half the total, such a need exists because of acute problems in the family in which the child has been living. In 49 cases the problems are so serious as to raise a question about the suitability of the relative's or guardian's home.

In his attempts to resolve the problem of a child's being in an unsuitable home, the worker naturally begins by evaluating the situation in the child's own family. Often, the worker finds that the parents can offer the child a better emotional atmosphere than can the relative or guardian. The workers have found that in 32 cases—in some but not all of which the relatives' homes are unsuitable—the children might eventually be returned to their own families.

Few of the relatives' or guardians' homes regarded as unsuitable for the children involve physical neglect, but the incidence of emotional and psychological neglect is high. This finding emphasizes the utmost importance of looking past the usually stable physical appearance of the caretaker's home and examining the interactions and the true relationships of the persons who live in it. For example, some of the children

in these cases are living with grandparents who are too old to rear children with patience. Many of these grandparents have failed to rear their own children successfully—in the sense that as adults their children have failed to conform with society's expectations—and so have a strong need to try again with their grandchildren. This drive to succeed as parents now causes them to take extreme attitudes in relation to the children—that is, to be either overly rigid or overly permissive. Very often their reasons for taking a child into their homes are so tied up in their own needs for satisfaction that they have become completely blinded to the child's needs. For example:

A couple in their 60's took their three preschool age grandchildren into their home when their son and his wife separated. The grandparents had never approved of their daughter-in-law and consistently denied to themselves and to the outside world that their son's behavior had anything to do with the separation. Just before taking the children, the grandmother, who had spent most of her life as a housewife and mother, had secured a part-time job. She was enjoying working and establishing the kind of home she had always wanted and resented having to relinquish her job and return to child care. The children's father was usually unemployed and, therefore, the grandparents received no financial support for the children until they applied for assistance.

Because the grandparents did not allow the children's mother to come to the house to visit them, the children were taken every week to their father's apartment where the mother would go to see them. These visits proved to be disastrous as the mother and father always spent the time arguing.

The worker received the impression that the children were suffering greatly under this arrangement. The grandmother did not have the patience and energy to keep up with three very active children. She could not see them as individuals, but treated them all alike even though they had very different personalities and very different needs. Seeing her retirement "dream house" constantly cluttered with toys, she became very strict about neatness and cleanliness. She could not tolerate the noise children normally make at play and did not allow the children to go out to play with other children.

Neither grandparent had any understanding of the children's emotional needs—their attachment to their mother and desire to live again with both of their parents—or of the relationship of these needs to the hyperactive jolliness of one child and the quiet, withdrawn manner of another, the older child's episodes of stealing, and the enuresis of the two younger children. Just as they had denied that their son had problems, these grandparents also denied that their grandchildren had problems. In the meantime the children were becoming increasingly disturbed.

Through a year of intensive casework service to this family, the worker was able to help the grandparents relinquish the care of the children. After many interviews with both parents of the children, the worker decided that the father would probably never be able to offer a home to his children, but that the mother had a great deal of love and strength to offer them.

However, the mother was not ready emotionally to take them at the time that they had to be removed from the grandparents' home, and, therefore, they were placed temporarily in a foster home. The mother is now working very closely with the agency in an effort to establish a home for the children. She has become involved in psychiatric counseling, has a steady job, and plans to take the children back with her within the next 6 months.

In the foregoing case, the grandparents were not physically or emotionally equipped to raise their grandchildren, but they needed a great deal of help to be able to admit this and to begin to feel right about it.

Another very destructive force exists for the child whose relatives or guardians have a great need to receive overt displays of appreciation and undivided loyalty from the children for whom they are caring or a need to remind the children constantly of their parents' inadequacies. Often a caretaking relative believes that the children's parents have disgraced the family. The child is told that he is "just like" his father or mother when his behavior does not please the relative. The relative sees the child not only as resembling the errant parent but as destined to turn out to be just like him—a view that without intervention can become a self-fulfilling prophecy. The child who is so regarded almost always feels some degree of loyalty and love for the disparaged parent and at the same time feels guilty for having such an attachment. The child, therefore, finds some way to cope with the situation, but seldom one that is healthy for him or acceptable to other people.

In some cases, the agency has found relatives who have taken a child into their homes primarily out of a sense of family obligation or duty, and without regard to their ability to cope with the child and his problems or to a consideration of how their own children will accept the necessity of sharing their parents and their home with another child.

In some situations, especially in cases where the children are living with legal guardians, the natural parents have never been able to accept the idea of having their child live away from home and so have prevented the child from making a satisfactory adjustment to his new home. For example:

Two young parents each drank constantly to the point of oblivion, leaving their 11-year-old daughter to assume complete responsibility for their 2-year-old son. A complaint to the court resulted in a neglect petition being filed against the parents, but the mother died of acute alcoholism before the court hearing. The court committed the children to the custody of the children's uncle and aunt.

The children's father could neither admit that he had a problem with alcohol nor accept the children's removal from his

custody. The daughter was very upset about the court order and wanted to remain with her father. The aunt and uncle, a couple in their 50's, had no children of their own. They had known about the family situation for a long time but they had been reluctant to interfere. They took the children into their home although their niece made it clear that she did not want to live with them.

Throughout this placement, the father has maintained close contact with his daughter, attempting to use her as a replacement for his wife and trying to prevent her from accepting her new home. Consequently, the girl feels that she is the only one who can take care of him. The agency's plan to help this father relax his dependency on the daughter has been futile as he refuses to see the worker. In spite of the intensive casework service being provided both the relatives and the girl in an effort to help them accept one another, the aunt and uncle are beginning to feel that they cannot continue to keep the girl in their home, for she refuses to accept them as parent substitutes.

Use of resources

Over the past year, the agency has removed nine children from the homes of relatives or guardians and placed them in foster family homes, but it has received many more requests for such replacements. The agency is at present working with several families to find suitable homes for children who are being "evicted" from the homes of relatives or guardians, and is giving intensive service to other families in an effort to avoid such an outcome. In some instances, almost immediately following the request the relative or guardian has impulsively returned the child to his parents or placed him with other relatives. In other cases the agency has responded to a call for help from the child's caretaker by making arrangements for the child to be seen at a mental health clinic, the Big Brothers, or the school's guidance service. The agency has used many community resources in an attempt to keep children with their relatives or legal guardians when this has seemed the best arrangement for the child.

Several children in these special caseloads have been committed by the court to agencies in other localities, which have referred them to the Baltimore County Department of Social Services for public assistance because the relatives with whom the child is living reside in Baltimore County. In these cases, the agency into whose care the child has been committed remains legally responsible for the child and reactivates its involvement in the case if the child seems to need replacement. The two agencies work very closely together when this occurs. The Baltimore County Department of Social Services prepares the child, the relatives, and the parents for the re-

entry of the other agency into their lives, supplies the other agency with a full report of what has occurred during the Department's responsibility for the child, and provides the services needed to hold the current placement together until the other agency can arrange for the child's replacement.

Some implications

Through its experience with special caseloads the Department's staff has become convinced that children placed with relatives and guardians are not necessarily living in the ideal situation for a child who must live away from his parents. Certainly, family ties are important and in many cases the child's relatives can offer him a healthy experience. Certainly, when a child cannot remain with his own parents, a home within the family constellation should always be considered for him before foster care. However, an evaluation of the relative's home is as necessary for the protection of the child as is an evaluation of a prospective foster home.

In the great majority of cases in the special caseloads here described, the children had been placed with relatives or guardians without the benefit of any home study. The sad result has been that in many cases children have been living with relatives or guardians who do not display any degree of sensitivity toward them or any understanding of the reasons they were separated from their parents and who, in many cases, cannot share the children with their own parents. Too often the child himself does not understand why he is not living with his own parents and, therefore, has many unresolved feelings and conflicts about his identity.

Sadly, too, the original reason for the child's separation from his parents has been related primarily to the parent's financial difficulties. In such cases, the arrangement for the child's care has usually been made with an understanding between parents and child that it will be temporary and then, without any real decision, it has been dragged on into long-term care. Too often, when a parent feels that he (or she) is ready to resume the care of his child, the situation turns into a custody struggle between

the parent and the relative or guardian that may even end up in court. In such situations, the child is almost always caught in the middle, frequently with disastrous results.

In the Baltimore County Department of Social Services, we believe that by providing needed services to all the parties in such cases the workers can help resolve some of the problems preventing the children from having as normal a life as possible in their "home away from home," or better still, that we can reunite many of them with their parents. However, we have come to the conclusion that if the workers are to give these cases the kind of service needed, their caseloads should be limited to a maximum of 35 cases.

We believe that this experience has important implications for foster care workers, who often consider removing children from foster care for placement with relatives; for foster home study workers, who are continuously concerned with the question of what constitutes a good home for children; for AFDC intake workers, who are the first to receive these applications; and for AFDC workers, who, in many agencies, serve the types of cases described here.

The experience has led us to conclude that this type of case must be given intensive service for at least the first 6 months after it comes to the agency's attention, after which intensive services should continue for as long as needed. We have also come to realize that all pertinent persons in the case should be seen by the intake worker—the child's parent or parents, the child, and the relative or guardian applying for assistance for the child; that the agency's expectation should be made clear to the family providing care, an evaluation of the child's situation should be made, and a plan for his future considered; and that in cases where the relative's home seems best for the child, the relative be encouraged to consider offering the child a sense of permanency by adopting him, if this is possible, or securing legal custody of him through the court.

We trust that this experience will encourage other agencies to look at children's placement with relatives or guardians with more awareness of the many pitfalls involved.

PARENTAL

and

COMMUNITY

NEGLECT

twin
responsibilities
of
protective
services

HAROLD LEWIS

Community neglect and abuse of children are as old as recorded history. Yet rarely have communities perceived their own behavior as neglectful. The Spartans, the New England factory sweatshop owners, the Southern slaveowners, all believed their treatment of children to be in the best interest of society. Only as we examine their social practices, free of their ideological blinders, do we see how neglectful were their acts, how victimized were children in their times. It is probably wise to assume that in this country today, despite our apparently more enlightened views, we are equally susceptible to ideological self-deception. Certainly there is ample evidence that our society is constantly generating neglected, victimized children.

Parental neglect has always appeared unnatural and punishable. Care of one's own offspring is thought to be an instinctual parental response. Those who lack this "instinct" and who fail in the parental role meet with societal disapproval and invite society's intervention in their family life to protect their children. Yet rarely have neglecting parents perceived their own behavior to be as reprehensible as it appears to persons outside their frame of reference.

Both community and parental perspectives can be self-deceiving. Only as we introduce a new environment, one that permits us to judge the behavior of parents and communities outside the context that shaped their perspectives, do we gain new insights

into old patterns. This lesson should not be ignored by those seeking new direction for protective services.

I consider *parental neglect* as existing in families where there is evidence of persistent, inadequate, insufficient provision of child care by the adult, or adults, responsible for the child or children and where the adult's behavior and attitude offer little or no likelihood of improved care without some outside intervention. I consider *community neglect* as existing where there is evidence of persistent, inadequate, insufficient provision of resources for child care by community authorities and where the behavior and attitudes of such authorities offer little or no likelihood of improved provision of resources without some outside intervention. Thus, my definition of child neglect includes both parental and community neglect. In either case, it involves two types of judgment: (1) a judgment of conditions observed; and (2) a judgment of behavior and attitudes, based on evidence of opportunity, capacity, and motivation for change. It is my contention that the child protective program must be concerned with both types of neglect and must be equipped to make both types of judgment and to act on such judgments.

On the basis of data derived from studies¹⁻⁶ of the recurrence of neglect in families known to protective service agencies, it must be concluded that—

1. There is more parental neglect of children than is detected—much more than is reported, and a great

deal more than becomes known to the protective agencies and the courts.²⁻⁴

2. Cases of parental neglect that do become known to agencies constituting a community's network of educational, health, and welfare services tend to be concentrated in neighborhoods characterized by the low income of the residents, the prevalence of deteriorating housing, and the scarcity of cultural resources.^{5, 6}

3. Even in neighborhoods with a higher than average incidence of known parental neglect, evidence suggests that less than half the cases of neglect identified by persons professionally involved in serving the families of these neighborhoods get reported to the protective service agency.⁴

4. Types of parental neglect vary in their likelihood of being detected, in the kind of persons likely to observe the neglect, in the willingness of the observer to report what he has seen, and in the probability of the family's receiving service from a protective service agency.

Conditions that are accepted as evidence of neglect vary in degree of visibility, repetition, and duration. Conditions with high visibility, for example, include physical deprivation, inadequate and insufficient clothing, lack of personal hygiene, and school truancy. Conditions with low visibility include irregularity of meals and sleep; unwholesome selection and preparation of food; inappropriate and intolerable discipline and lack of guidance; inconsistent affectional relationships. Reporting sources vary in standards used to judge neglect, the kind of neglect they are likely to witness, and willingness and ability to report the neglecting parents. Community protective services vary in the scope of their programs, in their receptivity to reports of neglect, their requirements and limitations in providing services, and in the degree of compulsion they feel for reporting back on neglect cases received through a systematic community reporting system.¹

At the neighborhood level in large cities, it is fairly obvious that parental neglect and community neglect go together, and may, in fact, give each other a helping hand. Truancy occurs when schools are inadequate. Hazardous conditions, such as unsafe dwellings, improper food preparation, dietary imbalance, and poor home management, exist for children in families living on inadequate assistance grants. Children's medical needs are ignored in families living in neighborhoods where clinical facilities are lacking or

inadequate. Irresponsible parental discipline and supervision occur in neighborhoods where policing, lighting, trash removal, and recreational space and opportunity are inadequate. In such ways, parental and community neglect feed on each other, presenting an unholy alliance not easily overcome by sporadic measures directed first at parental, then at community, neglect.

The present procedures for casefinding in protective services, whether public or voluntary, seem to "screen out" as often as they "screen in" children needing service. If the protective agency fails to interpret its programs to various segments of the public, if it builds an image that discourages referrals from neighbors and relatives, if it restricts eligibility for service to families with certain types of problems and to those living in specified geographic areas, and if it sets time limits on the continuation of service to individual families, it eliminates from protection many children living in families in which conditions of neglect exist.

Obviously, therefore, any serious effort to protect children from neglect must face up to the following limitations: (1) The significant weaknesses in present casefinding procedures; (2) the substantial evidence of professional oversight; (3) the uneven geographic distribution of neglect-prone families; and (4) the uneven and inadequate provision of neighborhood facilities and services for children whose families are especially vulnerable.

Organizational patterns

After a neglect situation or a neglect-prone family is identified, what is available organizationally and programatically to assure protection for the child and help for the family? The picture varies city by city and reflects the full range of influences shaping the local pattern of child welfare services. Studies^{1, 7} of the effects of protective services suggest the need for experimentation with new patterns of service organization, new methods of providing service, new types and combinations of programs. Such studies are consistent in reporting that current services achieve only partial success with many families and little or no success with chronically problem-ridden families—those families known to many community agencies over long periods of time. Rather the studies show that families once provided protective service often come to their attention again with recurring evidence of neglect. In many communities existing organizational patterns and the programs they offer do not

achieve a high level of success in helping neglecting parents and their children; they are even less successful in preventing neglect.

More disturbing, however, is the evidence that the persons responsible for maintaining such ineffective organizational patterns are probably not fully aware of the overall effect of present patterns on the delivery of services. One study⁸ suggests that this may be explained in part by the fact that persons in key positions at different levels of community responsibility for protective services tend to a "horizontal" perspective—seeing as primarily or exclusively important the functions for which they are directly responsible. When such persons look up or down at other levels of organization and program affecting the way service is provided, it is usually to claim a success on their own level, to question whether the other levels are achieving anything, and to ask for more "accountability" for resources expended. Communication channels between people providing direct service to families and the leaders, lay and professional, on the community planning level, is so rare as to be negligible. Mutual understanding and support will not be forthcoming in such an inadequate communication network.

Thus, efforts to change a pattern of neglect—whether parental neglect or community neglect—must include efforts to evolve new channels of communication, new forms of involvement, and new program content. Experimentation in these directions ought to encompass both parental and community neglect and ought to absorb a large portion of the energies of the protective agency, public or voluntary.⁹

A brief comment on the organizational pattern of community services is in order. Families known to protective service agencies, particularly the chronic cases, are frequently known to many other agencies as well. Perhaps the most disturbing evidence one can cite of the inadequacy of the present service picture is the fact, long recognized by some professional persons and highlighted by a recent study,⁴ that many cases of neglect identified by staff members in various kinds of agencies are apparently not referred to the protective service agency unless these troubled families *make trouble about their trouble*. The different forms of rationalization offered to excuse this practice are derived from the parochial perspective of persons operating within an environment that provides an ideology they are unable to escape. The inadequate coverage of neglect situations is not the only disturbing result. Almost as disturbing is the

destructive effect such a practice has on the self-image of the agencies involved, on their staff members, and on their relations with other agencies.

Community neglect

While parental neglect is often overlooked in the functioning of the present network of services to children, community neglect is almost totally ignored as a direct service responsibility by most of the agencies in this network.

Public and private agencies that primarily serve neglecting and neglect-prone families need to ask themselves the following questions: What are the agencies' goals? How can they hope to achieve them? To formulate clear answers to these questions, they will have to consider the following crucial points:

1. If the current pattern of detection and reporting remains undisturbed, the cases finally referred for protective service can be expected to show extremes in deterioration, little evidence of hope, characteristics of acute crises, and chronic depletion of material and emotional resources. Such cases will have defied the efforts of other agencies to deal with their problems and the factors generating these problems.

2. In the majority of these cases, neglect will not "recur" after the agency terminates contact with the family, for it will still be there as a chronic condition. What will recur will be crises. In the University of Pennsylvania's studies of neglect cases, the investigators found that 25 to 50 percent of the cases active at any one time in the principal protective service agency in one large urban community were previously known to the same agency. Of all cases previously served, close to 60 percent returned again for service within 5 years after termination of the agency's service, and many returned three, four, or even more times.¹⁰⁻¹² Moreover, when the families returned for service, their problems had changed little since their previous contact with the agency. What brought them back was the eruption of a child-care crisis that had previously been identified and temporarily brought under control.^{6, 7, 12, 13}

3. During the period of agency contact with the family, its service will most often be directed toward parental neglect—helping the family reorder its own life by identifying the parental roles and deficiencies within the family and using both the influence of psychological relationships and pertinent com-

munity resources to effect a desirable change. But community neglect as evidenced in shum housing, insufficient family income, overcrowded and understaffed schools, inadequate public services, and limited cultural opportunities will be affected hardly at all.

After termination of service, neglecting families nearly always remain in or return to an environment that fails to support the progress achieved during the period of service. Removing the children from such families, and thus from the deteriorating environment, represents a drastic wrenching of an organic unit. While some children may have to be removed from their families because the relationships in the home no longer appear capable of sustaining the children's health and well-being, long experience with the detrimental effects of separating a child from his parents has cautioned most agencies against relying on removal as a simple solution. Yet, even when an agency does recommend such drastic action, the court frequently puts off ordering the child's removal for reasons which may or may not be related to the parental neglect alone.¹⁴

Thus, the evidence on the kind of service provided to protect children hardly complies with the ideals social agencies espouse, the planned action they profess, the commitment they proclaim, and the results they would like to believe are being achieved.

Suggested directions

What should be the direction for child protective services in light of the foregoing conclusions? I would suggest the following policies:

1. The child protective service should continue and intensify its *focus on the child*, basing its efforts to prevent, modify, and eliminate both parental and community neglect on the condition and needs of the child and his family. Its program and services should reflect its role as the heart and conscience of the community concerning the welfare of the community's *most threatened children*. Its goal should be the promotion of those community conditions (housing, schooling, sanitation, health) and resources (medical services, professional personnel) that will prevent children from undergoing the destructive experience of neglect.

2. The clientele of the child protective agency should encompass all persons and organizations who

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do not accept their responsibilities in regard to children and whose behavior and attitudes give little evidence that salutary change will take place without outside intervention. It should include those elected officials and prominent citizens responsible for the allocation of community resources who fail to respond to demonstrated need and those organizations and public bodies that are charged with responsibility for meeting identified needs but persistently fail to fulfill their charge. This means the protective agency's policies and procedures should direct the agency's board and staff to intervene at the family, neighborhood, organizational, and community-wide levels to protect children threatened with neglect.

3. With the sights of a protective service thus raised, everyone who takes on the responsibility for providing protective service should be regarded as an activist on behalf of the welfare of the community's children. The board of the voluntary protective service agency should consist of persons willing and able to engage persons living in the community in action to remedy community deficiencies contributive to neglect. The board should provide both the leadership and the perspective for such action and through its involvement and commitment hearten the agency's staff members who must daily and hourly deal with the effects of neglect on families and children with inadequate resources for the task.

4. The direct services of the child protective agency should be carried out by a dedicated, well-trained, and deliberately innovative staff and should be based on those principles of practice that have been found to be effective¹ and on new approaches and new program emphases as well. New ways of providing service might include—

- Casefinding at the neighborhood level, tied in with early detection and intervention. For example, the child protective service might be set up as a

neighborhood resource, as available to families as are schools, clinics, and police stations, and be ready to experiment with new kinds of programs, policies, and procedures designed to change the image of protective service as a service of last resort "too late involved, too soon withdrawn."

- Efforts to involve persons who are neglecting their responsibilities to children in setting agency goals, providing service resources, and revising the agency's methods of working in their own and the children's behalf. The agency's board and staff would then be serving not only as agency representatives and client advocates, but also as promoters of responsible citizen participation.

- The encouragement of a variety of methods of providing service, for example, through group discussion, informal education, the use of homemaker aides, community organization, and public interpretation.

Each of these policies can, in principle, be adopted by either a voluntary or a public child protective service. However, the public child protective services are now struggling, and will for some time have to continue to struggle, to provide coverage for all children who are so neglected as to need protective services as a last resort. A concerned community that recognizes this fact—a result of longstanding community irresponsibility—may turn to its voluntary protective agency, if it has one, as a social instrument not only to supplement the public agency's efforts, but also, through experimentation and innovation, to demonstrate possible ways of achieving more success in both preventing and alleviating child neglect. As experience incorporates the results of such effort into the public services, new tasks will be defined for the voluntary agency.

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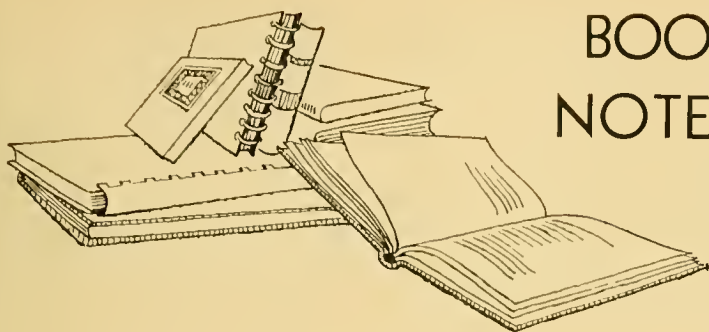
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... human warmth in our schools as well as in our other institutions will be one of the best ways to help our children and youth meet the stern disciplines of the times.

A. John Holden, Jr., Vermont Commissioner of Education, at the 1960 White House Conference on Children and Youth.



BOOK NOTES

INFANT, PERINATAL, MATERNAL, AND CHILDHOOD MORTALITY IN THE UNITED STATES. Sam Shapiro, Edward R. Schlesinger, and Robert E. L. Nesbitt, Jr. Harvard University Press, Cambridge, Mass. 1968. 388 pp. \$7.95.

This report analyzes trends from 1957 to 1964 in maternal, infant and perinatal, and childhood mortality in the United States, devoting a section to each of the three subjects. In a closing section it presents information concerning provision of health services and health resources in relation to facilities, health manpower, and financing. Trends in mortality are illustrated in comparisons of 3-year average rates, centered on two or three decennial census years, or in some cases, as with the trends in infant mortality, in long-term annual series.

The authors associate the slowness in the reduction of infant mortality in recent years with an increase in the proportions of births in comparatively high risk groups of very young mothers and mothers with many prior pregnancies; an increase in the proportion of infants with low birth weight, particularly in the nonwhite portion of the population; little or no improvement in perinatal death rates among the offspring of women with poor obstetric histories; and only slight or no improvement in the perinatal death rates among the offspring of women with obstetrical complications. They point out that nonwhite infants have a death rate almost twice as high as white infants.

The authors associate the faster reduction in maternal mortality with major advances in the medical arts, particularly the widespread development of blood banks, reduction in traumatic

obstetrics, and advances in chemotherapy, and in management of Cesarean section and anesthesia. Among the unsolved problems they mention are large differentials in maternal mortality rate between white and nonwhite mothers, unfavorable to the latter; large differentials between geographic areas, unfavorable to rural; and little progress in prevention of fatalities attributed to septic abortion.

In regard to comprehensive health care, the authors point out that population growth and changing composition in large metropolitan areas have complicated the provision of services and that the expansion of facilities has not kept up with the needs.

The book contains 13 tables, many of which are multiple in reference to a common topic. The appendix contains 25 tables on infant and perinatal mortality, four on maternal mortality, and eight on childhood mortality. Forty-five figures illustrate the text. Included are figures and discussion of infant and perinatal and childhood mortality in 11 other countries.

THE PREGNANT TEENAGER: a medical, educational, and social analysis. Howard J. Osofsky, M.D. Charles C Thomas, Springfield, Ill. 1968. 124 pp. \$6.75.

The pregnant teenager, who faces major medical as well as social and educational problems, "is indeed an individual at high risk," according to the author of this book. An associate professor of obstetrics and gynecology at the State University of New York, he bases his observations in part on his work as director of the Young Mothers Educational Development Program, which provides medical, edu-

cational, and social services for pregnant girls in Syracuse, N.Y., under the auspices of the local board of education, the county health department, and the Upstate Medical Center of the State University of New York.

In examining the scope of the problem, the author discusses the effects of out-of-wedlock pregnancy on the marriage rate among teenagers, on the economy, and on the girls themselves as adolescents. In attempting to answer the question of why pregnant teenagers are at such high risk medically, he finds answers in adolescence itself and the frequent concomitants of out-of-wedlock pregnancy—the failure to seek medical care early and the inferior quality of medical care often provided to the poor, who account for a large proportion of out-of-wedlock births. Similar problems affect the teenage girl's ability to receive appropriate social services, he says.

The author also examines the "complex problem" of providing continuing education for pregnant girls, and the "touchy problems" of making contraception and abortion available to them.

AMBULATORY PEDIATRICS. Edited by Morris Green, M.D., and Robert J. Haggerty, M.D. W. B. Saunders Co., Philadelphia, Pa. 1968. 970 pp. \$22.50.

Containing articles by 117 pediatricians, other medical specialists, and members of other professions concerned with the health care of children, this book discusses in detail the major aspects of health supervision and medical care of nonhospitalized children. The papers are grouped in eight sections, dealing with aspects of pediatric education; organization of clinical services; the job of the pediatric clinician; social problems in pediatrics; management of symptoms; health growth and development; long-term illness; and episodic disorders.

In addition to specific diseases, the book discusses, among other topics, the preparation of children for hospitalization, genetic counseling, and the pediatrician's role in prenatal and post-partum care, work with unmarried mothers, adoption and foster care, juvenile delinquency, physically abused children, the migrant child, adolescents with venereal disease, the gifted child, and school underachievers.

It also discusses school phobia, suicide in children, and the effects of divorce and other family crises on children.

SOCIAL SERVICES TO THE MENTALLY RETARDED. Helen L. Beck. Charles C Thomas, Springfield, Ill. 1969. 207 pp.

Based on the author's experience as chief psychiatric social worker in a handicapped children's clinic and as a school social worker, this book presents a descriptive account of mental retardation and the specific contribution of social services to the alleviation of the problem. It emphasizes the behavioral

manifestations of mental retardation, the parents' emotional reaction to the problem, and the role of the professional social worker and of community social services in facilitating the most satisfactory adjustment to it.

The first chapter lists the known causes of mental retardation and points to the need for an integrated multidisciplinary approach to dealing with it. The second chapter describes the settings in which one may find a retarded child. The next three chapters present some of the behavior manifestations of retardation, discuss its social implications, and describe some of the pro-

grams developed to serve retarded persons and their families.

There follow two chapters on social work processes, with case examples to illustrate the use of the casework and groupwork methods in helping parents understand better their child's condition, their own reaction to it, and ways they can help him develop his potentialities; and a chapter dealing with the behavior problems of the child at various stages of growth and development; and the final chapter stresses the need for social workers to participate in the new programs concerned with mental retardation.

guides and reports

DIFFERENTIAL USE OF MANPOWER: a team model for foster care. Six papers presented at the Illinois Beach Conference on Differential Use of Manpower, with an introduction by Marion P. Obenhaus. Child Welfare League of America, 44 East 23d St., New York, N.Y. 10010. 1968. 49 pp. \$1.60.

Describes a model for using teams of social workers with different levels of training as a means of meeting the manpower crisis in foster care, and discusses its implications for social work practice and training.

VULNERABLE CHILDREN: three studies of children in conflict: accident involved children, sexually assaulted children, and children with asthma. Lindy Burton. Schocken Books, Inc., 67 Park Ave., New York, N.Y. 10016. 1968. 277 pp. \$6.50.

Describes the family environments, behavior, and personality needs of 20 Belfast children between the ages of 5 and 15 years of age who had been hospitalized following road accidents, 41 children who had been sexually assaulted, and 25 Belfast children with

asthma. In each group, the author found evidence of emotional problems in the child before the accident, assault, or illness occurred.

DAY CARE AIDES: A GUIDE FOR INSERVICE TRAINING; and SELECTED READINGS FOR DAY CARE AIDES. Mary Watson Palmer, editor. National Federation of Settlements and Neighborhood Centers. 232 Madison Ave., New York, N.Y. 10016. 1968. 98 pp. \$2; 90 pp. \$1.25.

The first of these two companion handbooks contains guide material for conducting nine training sessions for day-care aides, focused on an introduction to the program, working with children, music and rhythm, finger play, arts and crafts, language development, child development, day-care goals, and problem situations; the second presents a listing of selected readings for trainees.

CHILD CARE IN HEALTH AND DISEASE: symposium to commemorate the dedication of the Silvain and Arma Wyler Children's Hospital and the Joseph P. Kennedy, Jr. Mental

Retardation Research Center, August 29-September 2, 1966. University of Chicago. Edited by Albert Dorfman. Year Book Medical Publishers, 35 E Wacker Drive, Chicago, Ill. 60601. 1968. 390 pp. \$17.50.

Contains 28 papers on child care in relation to various aspects of health problems and diseases, presented under eight heads: problems of child health care throughout the world; law and social policy for children; mental retardation; learning and language; cardiopulmonary problems; modern advances in important areas pertinent to childhood diseases; basic science aspects related to pediatric problems; and basic molecular biology and genetics.

THE SOCIAL WELFARE FORUM 1968: official proceedings; **SOCIAL WORK PRACTICE, 1968:** selected papers, 95th annual forum of the National Conference on Social Welfare. San Francisco, Calif., May 26-31. 1968. Columbia University Press, 440 West 110th St., New York, N.Y. 10025. for the National Conference on Social Welfare. 1968. 236 pp., \$6; 207 pp., \$6.

The first volume contains 12 papers on the development of social policy in such areas as legal rights, work and income opportunities in urban slums, urban planning, and the elimination of bigotry and poverty. The second includes 12 papers on various aspects of social work practice.

HERE and THERE



White House Conference

The 1970 White House Conference on Children and Youth, previously planned for mid-February 1970, has been postponed until December 13-18, 1970, to give more time for planning. In preparation for the appointment of the President's Committee for the Conference, the Conference staff, under the direction of Joseph H. Douglass, has prepared a master plan for the committee's consideration. The plan envisages a conference broad enough in scope to encompass "the entire rapidly changing social scene" as it affects children and youth from the prenatal period to adulthood and charges the delegates with the responsibility for achieving such specific objectives as:

- Formulating plans for dealing with problems indigenous to various geographic settings such as innercity slums, suburbs, and rural areas.
- Indicating ways in which new technologies may be better applied to human services.
- Suggesting new approaches to working with "disaffected" young people.
- Recommending ways of dealing with unrest on college campuses.
- Suggesting new or improved methods of child care in families and institutions.
- Suggesting new ways of identifying emotionally ill children and adolescents.
- Developing strategies for identifying and encouraging talented children.
- Increasing public understanding of the activities necessary for developing nationwide comprehensive services for children.
- Explaining ways to increase young people's participation in political and civic affairs.

Under the proposed plan, the President's Committee would appoint a

number of task forces, each charged with preparing a report for the Conference on a specific cluster of problems, viewed from five perspectives: social deficits, social issues, pathological conditions, promising practices and developments, and action indicated.

As presently constituted, the master plan recommends a conference of some 5,000 delegates, approximately one-third of them young people under 22. Delegates would be recommended by the State governors, affiliates of the Council of National Organizations for Children and Youth, the Interdepartmental Committee on Children and Youth, professional organizations, youth groups, and such new organizations concerned with innercity problems as the Urban Coalition and the National Alliance of Businessmen.

By mid-March 1969, the governors of 47 States had appointed or designated State committees to prepare for the White House Conference. Many of them were already active State Committees on Children and Youth; others were new or reactivated committees. During the past year, these committees have been engaged in a variety of activities to determine and focus attention on the needs of children and youth within their States. Such activities have included—

- The sponsoring of opinion polls, State or regional conferences, ad hoc "brainstorming" sessions, workshops, youth hearings, and town meetings.
- The creation of regional or county organizations composed of young people and adults to study local conditions.
- The preparation of working papers on specific subjects.
- The collection of existing data and the conducting of surveys.
- The publication of newsletters and

the provision of consultation to interested groups.

Each State committee is expected to prepare a full report for the Conference, to be ready by the end of 1969, on the critical conditions and needs it has identified within its State.

Child welfare

About 607,900 children under 21 years of age were receiving child welfare services through State and local departments of public welfare on March 31, 1967—a 7-percent increase over the previous year—according to reports to the Children's Bureau. On the same date, about 215,000 children were receiving services through voluntary child welfare agencies and institutions. Because some children were being served by both public and voluntary agencies, the total number of different children receiving child welfare services has been estimated at 772,200.

Approximately 50 percent of the children served by public agencies lived in their own homes, 33 percent were in foster family homes, 10 percent in institutions, and 7 percent in adoptive homes. About 35 percent of the children served by voluntary agencies were in institutions, 26 percent in homes of parents or relatives, 21 percent in foster family homes, and 17 percent in adoptive homes.

Of approximately 1,400 child welfare institutions operating on the reporting date, 1,250 were under voluntary auspices and 150 under public auspices.

These and other data are contained in "Child Welfare Statistics, 1967" (CB Statistical Series No. 92). Single copies are available from the Bureau.

As a result of a 4-year demonstration project, the Family and Child Services of Washington, D.C., a voluntary social casework agency, has been authorized to operate 20 foster family group homes for the D.C. Department of Public Welfare. During the demonstration period from June 1, 1963, through December 15, 1967, the Family and Child Services employed 11 women to serve as foster mothers in their own or agency-rented homes for children who were then living at the District's large congregate institution, Junior Village, or who had already had several previous

unsuccessful placements. The demonstration was supported by Federal funds from the Children's Bureau and the Office of Juvenile Delinquency and Youth Development, Social and Rehabilitation Service.

The demonstration involved the use of strong casework support for the 11 foster families, each of which included an unpaid foster father and five foster children in addition to the couple's own children, if any. (See "Foster Parents as Agency Employees," by Catherine Pratt, *CHILDREN*, January-February 1966.) In six homes, supported in part by the Children's Bureau, the objective was to provide stability and security through permanent care. The objective of five of the homes supported by the Office of Juvenile Delinquency and Youth Development was to determine whether foster group homes could be used to keep groups of siblings entering foster care together and avoid institutional care. Although long-range care was not foreseen as a major need of the 29 children entering these five homes, 25 children did remain in the same homes at the end of the demonstration.

At the end of the demonstration period, of the 59 children served in the project, 53 had been in the same foster home from 9 to 49 months. Four had been returned to their natural parents. Two others had been placed in other types of care because they had been so disturbed that their foster parents had been unable to meet their needs.

The Family and Child Services staff found that 88 percent of the children made generally satisfactory adjustments within their foster homes, accepting routine, discipline, and placement; undertaking responsibility; participating in family activities; and demonstrating affection for foster parents and foster siblings. However, when each child's competence to handle the kind of ordinary life situations met in the community was rated, 16 were found about average, 19 slightly below average, and 18 markedly or extremely low. No child was rated above average.

Many of the children who had had previous foster care experiences remained unconvinced about the permanency of their placements, although all but two of the foster parents had become committed to long-term care. However, the staff of the agency saw evidence that the foster children were beginning to develop positive familylike

relationships and growing trust about the future.

In the judgment of the agency, seven couples did well with all the children in their homes; two couples did well with all but one child; and two foster mothers showed increasing inadequacy in functioning, which resulted in the closing of one home after the end of the project.

AFDC

Nearly half the women who responded to a 1967 sample survey of families in the program of aid to families with dependent children (AFDC) said they would use an increase in public assistance payments, if there were one, to buy more food. More than one-third of the respondents said they had postponed at least one rent payment to buy food during the previous 6 months. Almost half reported that there had been times during the same period when they had no money to buy milk for their children. Seventeen percent reported that some of the children in their families had stayed home from school at some time during the 6 months because they lacked shoes or clothing.

The survey, conducted by mail, consisted of 32 questions sent to 3,659 women in the program in the 48 contiguous States, by the National Center for Social Statistics, Social and Rehabilitation Service. Responses were received from 2,969 women. Among other lacks they reported were:

- Not enough beds for every member of the family—reported by 30 percent of the respondents.
- Not enough sheets or blankets to have one of each for each bed in the family—12 percent.
- Not enough furniture to seat every member of the family at mealtime—25 percent.
- Not enough tableware for the size of the family—21 percent.
- No inside running water—13 percent.
- No flush toilet—14 percent.

Many mothers reported that at least one member of the family had not obtained needed medical care in the 6 months before the survey because the family could not afford it. Thirty-nine percent of the mothers mentioned foregoing dental care; 29 percent, eyeglasses; and 25 percent, visits to a doctor.

The survey shows that 21 percent of the families had been receiving public assistance for less than 1 year; 31 percent, from 1 to 3 years; and 45 percent, more than 3 years. Almost 40 percent had received assistance at least two different times. Twenty percent of the women had been denied assistance at some time when they had applied for it.

More than three-fourths of the mothers said they thought professional welfare workers were at least "fairly understanding." More than half reported that, in addition to financial payments, public assistance had helped them in other ways, such as obtaining medical care, feeding their families, getting home furnishings and clothing, providing social or emotional support. Among those helped in other ways, about 7 percent said that a welfare department had helped them or their husbands obtain additional education or job training, and 2.4 percent said that a welfare department had helped some member of the family find or keep a job.

More than 40 percent of the women who responded had not gone beyond the eighth grade; 20 percent had graduated from high school; less than 3 percent had entered college. At the time of the survey, 8 percent were enrolled in additional training or education; of these, about one-third were studying for a high school diploma and one-sixth were taking business courses.

Day care

The number of children who could be cared for in licensed day-care facilities in the 50 States, Puerto Rico, the Virgin Islands, and the District of Columbia increased from 310,400 to 531,000 from March 31, 1965, to March 31, 1968, according to reports received by the Children's Bureau. The total number of licensed facilities—including day-care centers and family day-care homes, under public, voluntary, and independent auspices—increased from 23,707 to 38,400. Licensed day-care centers increased from 7,334 to 11,500; licensed family day-care homes, from 16,373 to 26,900.

. . .

Public child welfare services funds expended for direct care of children in day-care facilities increased from \$9.2 million in the fiscal year 1965 to \$14

million (preliminary figures) in fiscal 1968, with \$15.4 million projected for day-care expenditures in fiscal 1969. Of these sums, \$1.7 million of the 1965 expenditures were from Federal child welfare services funds, and \$7.5 million from State and local funds. Of the 1968 expenditures, \$3.7 million were from Federal funds, and \$10.3 million from State and local funds. Estimates for 1969 include \$3.4 million from Federal funds and \$12 million from State and local funds.

Additional Federal expenditures are made through the program of aid to families with dependent children (AFDC) for the care of children of mothers referred for employment or job training in the work incentive (WIN) program established under the 1967 amendments to the Social Security Act (see CHILDREN, March-April 1969, p. 79). Estimates in the President's budget for the fiscal year 1969 project a Federal expenditure of \$22.6 million for the care of children of persons referred for training in the WIN program. This will provide care either in preschool facilities, afterschool facilities, or in-home arrangements for an average of 49,900 children, largely on a purchase-of-care basis.

In 8,900 families receiving assistance in the AFDC program in late 1967, children between the ages of 6 and 12 were left to take care of themselves while their mothers were at work; and in 180 families children under 6 were left to fend for themselves. These facts were revealed in a study of working mothers in the AFDC caseload carried out by the National Center for Social Statistics, Social and Rehabilitation Service.

The study showed that 175,000 or 13.7 percent of all mothers receiving assistance through the AFDC program in late 1967 had either full-time (6.6 percent) or part-time (7.1 percent) jobs. Of these, 100,000 mothers had children under 6 years of age and 130,000 had children between 6 and 12.

An analysis of the child-care arrangements made by the mothers having children under 6 showed that 45.2 percent made arrangements for the care of the children in their own homes, provided by a relative or other person; that 30.1

percent arranged for the care of their children in someone else's home; that 17 percent made other arrangements for care—in group-care centers (8.6 percent), by the mother herself while working (7 percent), "other" (1.2 percent), and no care at all (.2 percent)—the 180 families already mentioned).

Arrangements of the 130,000 working mothers with older children were similar for care in their own homes, but only 15.2 percent arranged for care in someone else's home; 6.9 percent left the children to care for themselves; and 20.5 percent worked only during their children's school hours.

Family planning

Early in 1969, the President's Committee on Population and Family Planning, appointed by President Johnson in July 1968 (see CHILDREN, November-December 1968, p. 244), reported its recommendations for Federal action in relation to population and family planning. In making its recommendations, the Committee emphasized the importance of expanding domestic family planning programs intended primarily to further the health and welfare of the American people; of expanding Federal financial support for international programs; and of expanding efforts in research, education, and program planning.

In brief, its proposals for immediate consideration recommended that—

- The Federal Government take steps to expand family planning so that by 1973 such services will be available on a voluntary basis to all women who want but cannot afford them.

- The Department of Health, Education, and Welfare and the Office of Economic Opportunity develop specific 5-year plans to include service, research, training, and educational activities.

- The Office of Education assist appropriate educational agencies in developing materials on population dynamics and family life for all levels of education.

- The United States continue to expand its programs of international assistance in population and family planning as rapidly as funds can be properly allocated and effectively utilized.

- Specialists from other countries be invited to serve on advisory groups to the Federal Government for both domestic and international programs.

- The newly established Center for Population Research of the National Institute of Child Health and Human Development be expanded within 2 years into a separate National Institute for Population Research.

- The Federal Government provide basic support for existing population studies centers and for construction of additional centers primarily in universities.

- A Commission on Population be appointed by the President to report on the economic, educational, and social impact of population trends and report to the Nation by the end of 1970.

The Committee's report, entitled "Population and Family Planning: The Transition from Concern to Action," is available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. (Price: 30 cents.)

For youth

A 1969 National Summer Youth Sports Program to give 75,000 innercity young people a chance to participate in competitive sports was announced in March by Vice President Spiro T. Agnew. The program, to be carried out between June 1 and September 1, will make it possible for boys and girls between 12 and 18 years of age in 40 metropolitan areas to participate in swimming, gymnastics, track and field, basketball, and other sports at free day camps on college and university campuses. Under the overall direction of the President's Council on Physical Fitness and Sports, the program will be carried out by the National Collegiate Athletic Association with \$3 million in funds from the Office of Economic Opportunity.

About 120 colleges, junior colleges, and universities will operate the day camps, modeled on sports programs for youngsters from innercity areas conducted by Ohio State University in Columbus and the University of Southern California in Los Angeles in the summer of 1968. College athletic coaches will serve as supervisors and college athletes as instructors and counselors. Some of the programs will also include jobs for young people from the innercity areas.

Each day camp will operate at least 4 days a week for at least 5 weeks and will serve at least 200 youngsters. Ac-

tivities will include at least 2 hours of individual and team sports a day for each youngster. One meal will be served in most programs; nutrition and health education will be offered; and transportation and medical examinations will be provided. At least one activity will be designed for girls.

Astronaut James A. Lovell is consultant for the program.

More students from poor families in the United States entered college in the fall of 1968 than ever before, according to a recent analysis of college enrollment by the Office of Education. About 11 percent of the first-time full-time students who enrolled in institutions of higher education last fall were from families with annual incomes of \$5,000 or less, compared with 7.5 percent from the same income group in 1966. Much of the increase is attributed by the Office of Education to increased public and private aid made available to students following the Higher Education Act of 1965.

Education

On February 11, a statutory three-judge District Court of the United States for the Eastern District of Virginia decided that the Virginia tuition grant system was invalid and contravened the Constitution of the United States. Under the system, every child who applied could receive a State grant for tuition to a nonsectarian private elementary or secondary school. The court, in *Griffin v. State Board of Education*, following the United States Supreme Court's implied approval of recent rulings in similar cases, stated that the validity of a tuition plan must not "in any measure, no matter how slight, contribute to or permit continuance of segregated public school education."

In the Virginia case, the court interpreted the Supreme Court's refusal in 1968 to review lower court rulings invalidating tuition grant systems in Louisiana and South Carolina to mean that "... any assist whatever by the State towards provision of a racially segregated education, exceeds the pale of tolerance demarked by the Constitution." The further question, whether the tuition grant system did in fact contribute to the operation of a segregated

school system, was resolved against the school board even though no motive or purpose to discriminate was shown. The court pointed out that the results indicated a continuation of segregated education and that was deemed sufficient. The court acknowledged the fact that parts of the tuition grant system might not have discriminatory effect, but citing the intentment of the Supreme Court and noting the impossibility of enforcing the law on a partial basis, declared the statutes to be of no vitality and ruled that the entire program must cease.

The court made it clear that its ruling applies only to grants for children able to attend regular classes of public schools and not to grants for the benefit of handicapped children.

Denying the requested restitution of funds, the court simply enjoined payments after June 1969, thus allowing students to finish this school year under the now invalid tuition plan.

Twenty public school districts with high percentages of school dropouts have been chosen to prepare formal proposals for dropout prevention projects that may serve as models for other school districts under the new Dropout Prevention Program administered by the Office of Education. These districts were selected from among 369 that submitted applications for grants under the program.

The new program, authorized under title VIII of the Elementary and Secondary Education Act, makes grants available to local educational institutions in rural and urban areas for projects to develop and demonstrate educational practices—innovative methods, systems, materials, or programs—which show promise in reducing the number of children who fail to complete their education. To qualify for the grants, the schools must have a high percentage of children from families with annual incomes of \$3,000 or less and must have a high percentage of children who do not complete their elementary and secondary education.

The school districts chosen to submit proposals are at Tuskegee, Ala. (Macon County); Oakland, Calif.; Ft. Logan, Colo.; Hartford, Conn.; Miami, Fla. (Dade County); Honolulu, Hawaii; Paducah, Ky.; Balti-

more, Md.; Fall River, Mass.; Detroit, Mich.; Minneapolis, Minn.; St. Louis, Mo.; Trenton, N.J.; Chautauqua County, N.Y.; Dayton, Ohio; Philadelphia, Pa.; Shannon County, S. Dak.; Texarkana, Arkansas-Texas; Seattle, Wash.; and Riverton, Wyo.

Grant awards, which will go directly to the local institutions with approval by the State education agency, will be announced in June. The projects which are finally approved are expected to begin operation in July.

Allergies

The prevalence of allergies in 763 Denver public school students increased from 21 to about 28 percent between the eighth and the 12th grades, according to studies made in 1963 and 1967 by Geraldine L. Freeman, M.D., and Samuel Johnson, M.D., with support from the Children's Bureau. The increase was largely due to the acquisition during the period of seasonal hay fever among 5 percent of the students.

In 1967, about 21 percent of the high school seniors showed signs of hay fever; 9 percent, perennial nasal allergies; 2.5 percent, asthma; and 2 percent each, eczema and hives. Nasal allergies improved or disappeared in 20 percent of the students affected between the ages of 13 and 17, but, at the same time, such allergies developed or became worse in another 25 percent. At the time of the 1967 survey, 43 percent of the students with allergies were receiving medical care.

The study found correlations between reporting of allergies in students and a high socioeconomic level (43 percent of students from families of high socioeconomic level had present or past allergies compared with 24 percent of those from families of low socioeconomic level) as well as between allergies in students and a family history of hypersensitivity (75 percent of the students with allergies had a close relative with allergies). More of the children who developed multiple allergies retained their symptoms during adolescence than those who had a single allergy. The study found no association between hay fever and the subsequent development of asthma.

Allergies did not significantly affect

school attendance among high school seniors in 1967. Boys and girls with allergies, who missed an average of 5.1 days of school during the year, reported that about one-quarter of their absences were related to allergies. Senior girls with allergies missed an average of 1 day of school more than girls without allergies.

The survey was conducted by mail and telephone.

Vital statistics

The infant mortality rate in the United States dropped to 21.7 per

1,000 live births in 1968—the lowest rate on record and a decrease of 1.8 percent from 1967, according to provisional estimates released by the National Center for Health Statistics, Health Services and Mental Health Administration. The total number of infant deaths declined, from an estimated 78,200 in 1967 to 75,300 in 1968.

The 1968 birth rate also hit a new low in 1968—17.4 live births per 1,000 population. According to provisional information for 1968, a total of 3,470,000 births were recorded, a 1-percent decline from 1967 and the

lowest number since 1946. The fertility rate (number of births per 1,000 women from 15 through 44) continued a 12-year decline to 84.8 in 1968.

Marriages in 1968 reached the second highest number on record—2,059,000, or nearly 8 percent more than in 1967. The marriage rate of 10.3 marriages per 1,000 population in 1968 was the highest since 1951. Statisticians noted the current marriage boom is related to the high numbers of marriages and subsequent births immediately following World War II.

films on child life

Charges for rental or purchase may be obtained from distributors.

THE WAY IT IS. 16 mm.; 60 minutes; sound: black and white; rent or purchase.

Documents the efforts of a project, sponsored by New York University, in a junior high school in a disadvantaged area of Brooklyn, N.Y., to improve the academic achievement of seventh grade students with learning difficulties. Shows the teachers working with students in the classroom, discussing their problems at teachers' meetings, and visiting with the children's parents.

Audience: Teachers, parents, civic groups, and others concerned with the education of disadvantaged children.

Produced by: Harold Mayer Productions, Inc., for National Educational Television.

Distributed by: Audio-Visual Center, Indiana University, Bloomington, Ind. 47401.

MORE THAN LOVE. 18 minutes; sound; color; purchase.

Designed for boys and girls in the 11th and 12th grades, this filmstrip dis-

cusses the importance of good health practices in the earlier years of life before marriage to better the chances of having healthy children. It explains the dangers of some birth defects caused by poor diet, drugs, venereal disease, and prematurity, and emphasizes the importance of good prenatal care throughout pregnancy.

Audience: High school classes in health education, family life and sex education, social studies, and science; youth groups; and church and community organizations.

Produced by: Glenn Education Films, Inc.

Distributed by: Supply Division, The National Foundation-March of Dimes, 800 Second Ave., New York, N.Y. 10017.

ROBIN, PETER, AND DARRYL: THREE TO THE HOSPITAL. 16 mm.; 53 minutes; sound; black and white; purchase.

Produced specifically as an aid for teaching nursing students about the effects of maternal deprivation and children's reactions to hospitalization, this

film depicts the experiences of three children aged 2 years 10 months who are hospitalized for minor surgery and separated from their parents for the first time.

Audience: Nurses, nursing students, medical students, psychologists, psychiatric social workers, and family life education workers.

Produced by: Department of Nursing, Faculty of Medicine, Columbia University, with direction by George C. Stoney Associates.

Distributed by: Center for Mass Communication of Columbia University, 440 West 110th St., New York, N.Y. 10025.

FEEDING YOUR YOUNG CHILDREN. 59 frames; 13 minutes; color; purchase (includes guide containing script).

This filmstrip presents guidelines to help parents provide their preschool children with the kinds of food they need for proper nourishment and that are at the same time appealing to them. It explains how such factors as growth rate, activity, and body size may affect a child's appetite, and offers suggestions on ways of creating a pleasant mealtime atmosphere.

Audience: All types of parent education groups, and classes in home economics, family living, dietetics, and nursing.

Produced by: National Dairy Council.
Distributed by: National Dairy Council, 111 N. Canal St., Chicago, Ill. 60606.

IN THE JOURNALS

Birth control attitudes

Many births out of wedlock might be prevented if birth control services were available to sexually active unmarried teenagers, suggest the authors of an article in the February 1969 issue of the quarterly, *Journal of Marriage and the Family*. ("Birth Control Knowledge and Attitudes Among Unmarried Pregnant Adolescents: A Preliminary Report," by Frank Furstenberg, Jr., Leon Gordis, and Milton Markowitz.) The authors report the results of interviews with 169 pregnant teenagers seen at the Family Obstetrical Clinic at Mt. Sinai Hospital, Baltimore, Md., in the first 15 months of a continuing study begun in 1966. All were Negro girls of low-socioeconomic status. Among other questions, the girls were asked about their sexual patterns prior to pregnancy, their reactions to pregnancy, and their knowledge, use of, and attitudes toward birth control.

The authors report that most of the girls began sexual activity 2 or 3 years after menarche and became pregnant about a year later. However, the great majority (83 percent) said they confined their sexual activity to one boy and 85 percent said they were continuing to see the father of their expected child—findings the authors interpret as a tendency toward sexual constancy, rather than promiscuity, among such girls.

The authors also report that while two-thirds of the girls had been extremely upset when they first discovered they were pregnant, at the time of conception they had not attempted to prevent the pregnancy from occurring but had left it up to the boy to take whatever precautions were used, if any. Only 22 percent of the girls had used any female birth control method, and among those who had, few had used either pills or intrauterine devices—in fact, many of the girls expressed fears about the safety of these methods.

Most of the girls realized that they did not have adequate knowledge about birth control methods and, with few ex-

ceptions, seemed eager to learn about them, the authors report. They conclude that the success of any birth control program among adolescents will depend on dispelling misconceptions and alleviating anxieties about methods and making the methods more accessible.

A social dilemma

The essential need of seriously disturbed children who have been reared in poverty is to develop trust in another human being, say Herta Mayer and Gerald Schamess in the March 1969 issue of *Social Casework*. ("Long-Term Treatment for the Disadvantaged.") The authors are respectively child guidance clinic supervisor and consultant in group therapy for the Jewish Board of Guardians in New York City. Maintaining that such a process is "most effectively promoted by a long-term relationship with a stable person in a benign environment," they describe a treatment method that combines interview sessions, directed toward helping the child express and understand his feelings, with the provision of experiences intended to increase his sense of adequacy and independence.

White therapists dealing with Negroes, the authors warn, must be able to examine their own prejudices honestly, if they are to be able to help the client express his anger, hurt, and frustration.

Pointing out that learning difficulties often play an important part in the development of the child's pathology, the authors suggest that children with such problems need a benign person "who can increase the pleasure of learning" and that, in their experience, this person can sometimes be a tutor and therapist combined, working under a therapist's supervision—especially when the members of the family deny the existence of emotional problems.

They describe a case in which a Negro child born out of wedlock and his rejecting mother were assigned to the same teacher-therapist, who, in addition to helping them work through

their hostile feelings toward themselves, each other, and the white community, provided such practical services for the whole family as helping the child's older brother secure a job and working out better school programs for the other children. During the 4 years the services were provided, the boy gradually achieved greater self-respect and marked improvement in his school work and social relationships, the authors report.

In conclusion, the authors recognize the social dilemma presented by the demands of such long-term treatment on scarce professional time and financial resources in the face of the many social ills calling for remedy today. They insist, however, that treatment methods must be appropriate to the case and that therefore a range of methods, including both long-term treatment and "new methods of intervention," must be available.

Mentally retarded

Because of their commitment to making good the deficiencies in childhood environments, child welfare services have special relevance for mildly retarded children who have no obvious biological impairment, say Margaret E. Adams and Ralph W. Colvin in an article in the March 1969 issue of *Child Welfare*. ("The Deprivation Hypothesis: Its Application to Mentally Retarded Children and Their Needs.") The authors, both employed in research at the Child Welfare League of America when they wrote the article, cite numerous studies indicating that the retardation in many such children is a reaction to a conspicuously deficient environment within the family, the community, or both.

Early identification of the problem, in its manifestation or as a threat, is essential for preventing or alleviating environmentally induced retardation, the authors assert. They cite various forms of child welfare services that can be of help:

- Day-care services to provide an enriched environment.
- Homemaker services to improve the child's home environment.
- Parental counseling to help parents function more effectively.
- Services to unmarried parents to bring some form of stability to the child's life.

- Individualized foster care, especially placement in families in which the child's particular needs "are matched with the parents' wish to play a consciously rehabilitative role."

- Adoption, for children who are eligible for adoption and whose retardation, as indicated by careful social and psychological diagnosis, is not irremediable.

Iron deficiency anemia

Studies showing a high prevalence of iron deficiency anemia in infants and preschool children who live in the inner cores of our large cities should stimulate public health programs similar to those that wiped out rickets and scurvy from preceding generations of

children, Margaret F. Gutelius, M.D., declares in the February 1969 issue of the *American Journal of Public Health*. ("The Problem of Iron Deficiency Anemia in Preschool Negro Children.") She found iron deficiency anemia, as defined by a hemoglobin concentration below 10 grams per 100 milliliters of blood serum, in 29 percent of the 460 apparently normal children under 6 years of age who attended well-baby clinics at the child health center of Children's Hospital in Washington, D.C., in 1965.

Dr. Gutelius suggests that the actual incidence of iron deficiency anemia in Washington children may be higher than her study showed. Her study did not include 340 children who had previously had hemoglobin level determina-

tions at the health center because the doctors suspected they might have anemia, nor did it include the "unknown number" of children from poor, disorganized families who did not attend the health center.

Among the findings were: iron deficiency anemia reached a peak in children between 12 and 17 months of age, occurring in 65 percent of those in this age group; of the 17 children who were tested before they reached 6 months of age, one-third had anemia; severe anemia was present in only 7 percent of the children. Dr. Gutelius suggests that although many children overcome anemia between the ages of 3 and 5 years, their hemoglobin levels remain in the borderline range for many years.

READERS' EXCHANGE

KESSLER, ABLOH, AND SMITH: *Problems of reality*

The article by Jane W. Kessler, Grith Ablon, and Edith Smith, "Separation Reactions in Young, Mildly Retarded Children" (*CHILDREN*, January-February 1969), presents the main issues well. The comments on the meaning of various reactions in the child, the possibility of increasing mothers' ability to interpret behavior of the child, and the ease with which insensitivity can be rationalized are particularly well set forth.

The problem that is not discussed, however, has to do with reality. The article ends with acknowledgement that so intense an adult-child ratio, so complete a program, and so well oriented a research attitude can probably not be multiplied to reach a service level of significance. However, such demonstrations can serve as models from which principles can be derived, as in this paper, for application in more realistic situations.

The authors have, however, failed to face another aspect of reality. The

children are referred to as mildly retarded, though the IQ of the child in the case example is only 45. While in densely populated areas enough such children might be gathered together without bussing, which the authors apparently feel may exacerbate separation reactions, such cases are so rare in most other situations as to make bussing almost unavoidable. Furthermore, the children most needing the care described have mothers who, because of other duties or by reason of having to work, cannot spend several weeks in assuaging separation reactions or making them easier to endure. It may be that an evaluation will have to be made as to whether the assets of the program justify avoiding the living through of the separation anxiety. Indeed the separation anxiety may have to be experienced by the child whether or not there is a program.

In some cases, separation anxiety may have to be alleviated by having staff members of the school, who actually may be more mobile than the mothers, go to the homes of the children in the evening when working mothers are at

home. Or a visit may have to be made to the daytime caretaker of the child—a neighbor, a relative, or a day-care center. And it would appear that every effort should be bent to shorten the period in which separation reactions are important so that the program may be more useful in the real world.

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ANDRONICO AND GUERNEY: *Study needed*

The discussion on "filial therapy" and Head Start clarifies only that a psychotherapeutic aide may be therapeutic. ("Case Conference: A Psychotherapeutic Aide in a Headstart Program: I. Theory and Practice," by Michael P. Andronico and Bernard G. Guernsey, *CHILDREN*, January-February 1969, and Readers' Exchange, *CHILDREN*, March-April 1969.)

It seems to me that rather than continue to debate, the authors and discussors would do better to set up some sort of comparison, utilizing trial and control groups, to answer the questions which logically arise from their pilot observations:

- Was the natural history of development significantly altered?

• Was the change related to the therapy offered?

• What factors in the child and the Head Start program influenced the outcome?

• Was the therapy effective and economical, compared with other types?

I would ask the identical questions of the Head Start program itself.

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GIL: An expensive proposal

I would like to comment on the cost of the proposal made by David G. Gil in the November-December 1968 issue of *CHILDREN*. ("Mothers' Wages—One Way To Attack Poverty.")

In brief, Dr. Gil proposes establishing a system of family allowances, with a uniform annual amount of \$4,680 being paid to each mother with children under age 18. The amount would be reduced in an unexplained manner for such mothers who engage in employment. The proposal would be financed in a rather indefinite way—through the program of Old Age Survivors and Disability Insurance (OASDI) by raising the earnings base for Social Security contributions and from general revenues (apparently, solely as a result of eliminating the deductions for child dependents for income tax purposes).

No specific cost figures are given for this proposal, even though they are relatively easy to compute. About 29.4 million mothers would be involved under this proposal. One big question is the extent to which benefits would be reduced for working mothers, and then how many such mothers would cease work because it would no longer be attractive financially to be employed.

I estimate that at the minimum this proposal would cost \$115 billion per year currently, while at the maximum, it would cost \$140 billion. Increasing the OASDI earnings base and applying the current OASDI contribution rate to the additional taxable payroll would yield only \$5 billion per year, or far short of the needed revenues. Similarly, the additional income tax resulting from eliminating exemptions for child dependents would not meet much of the colossal cost involved. It might be pointed out that if the proposal were to be financed entirely by a payroll tax on

the present OASDI taxable payroll, a rate of 29 percent would be required according to the minimum estimate, and a rate of 35 percent of taxable payroll would be required under the maximum estimate.

Robert J. Myers
*Chief Actuary
Social Security Administration*

Author's response

I fully agree with Mr. Myers that compensating mothers for the essential task they perform on behalf of society would involve a considerable level of transfer payments. I differ, however, with his estimates. If all of the 28.6 million mothers in this country who have children under 18 years of age were entitled to wages the maximum cost would be under \$134 billion, assuming an annual wage of \$4,680 per mother. At the present time, over 9.9 million mothers are in the work force and thus would be entitled only to a small fraction of mothers' wages, thus decreasing program costs to about \$90 billion. Some mothers—and no one knows how many—might, of course, withdraw from the labor market once the mothers' wages became available, thus increasing overall costs of the program.

Experimentation would certainly be needed to gain an understanding of the effects of the program on mothers in the work force so that better fiscal prediction would be possible. Mr. Myers failed to note that the income on mothers' wages, even under current income tax law, would result in the recoupment by the Federal Government of at least \$25 billion. Furthermore, \$2.5 billion in current payments for aid to families with dependent children (AFDC) would be saved and the entire AFDC program would cease to exist—a highly desirable by-product of any income maintenance program. Additional savings in other public welfare programs would also occur.

Having raised some questions concerning Mr. Myers' cost estimates, I would submit that the proposal for mothers' wages should be examined in terms of its human values and long-range social and economic benefits, and more specifically in terms of social justice and equal rights for women, rather than in short-range fiscal terms. Eliminating poverty and relative deprivation

from our affluent society requires far-reaching redistribution of our national wealth and income as well as a major reorientation of our national priorities. What is needed are major reforms in our existing inequitable income tax system through higher tax rates for middle- and upper-income groups and closing some of the tax loopholes available to the well-to-do. According to a recent report to Congress by Joseph W. Barr, former Secretary of the Treasury, some \$50 billion in taxes are not collected annually because of special provisions serving selected interest groups.

If this country had a truly equitable tax program, then transfer payments of even \$100 billion or more would not be unrealistic. The issue then comes down to national readiness to reorganize our societal priorities, and to put social justice and equal social and economic opportunity for all, including all women, at the top of the national agenda.

When we view an activity as important and in the national interest, as we do our space program or our national defense, we are not discouraged by "colossal costs." Why then is "colossal" too high a price to pay for a better society?

David G. Gil
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correction

The editor apologizes for two errors that crept into L. Joseph Stone's contribution to the Readers' Exchange section of the March-April 1969 issue of *CHILDREN* (see p. 87): (1) parentheses instead of commas in a sentence that *should* have read: "In fact, neither 'congiton,' Piaget, Bereiter, nor psychoanalysis, Spitz or Deutsch is new; new, that is, in the sense of offering us new goals. . . ."; (2) a verb change in a sentence written to read: "But surely the educational goals of the two camps—whichever camp one takes to be manned by the good guys—are not different. . . ." Dr. Stone was commenting on an article by Milton J. E. Senn, M.D., "Early Childhood Education—For What Goals?" (*CHILDREN*, January-February 1969.)

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children

Comprehensive Health Care

Children's Rights—

in the Courts

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Pediatrician, mother, and child participating in a project to provide comprehensive health care for preschool and schoolage children in San Francisco, Calif. This is one of the 58 projects supported by the Children's Bureau in low-income areas throughout the country that are finding new ways to provide continuous, preventive, and remedial health care to children. (See pp. 130-137.)



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“But what can we do to gain their trust?”

A young pediatrician asked the question of a community aide during a team conference in his office in an inner-city neighborhood pediatric clinic, converted from a two-story family home. The pediatrician was concerned about the distrust he sensed in the mothers who brought their children to the clinic for care. He waited attentively for the answer as did the other members of the team present—a psychiatrist, a clinic nurse, a public health nurse, a social worker, and a licensed practical nurse.

“Smile a little, and don’t be in such a hurry,” answered the aide, herself a resident of the black ghetto neighborhood being served. “Look at us as though we were people.” She paused, then added, “But you do that here in the children’s clinic. It’s nicer here than in most clinics.”

But the young doctor persisted.

“I can feel my patients’ wariness. They sit across the room when they first come in instead of up by my desk. Not until after the second or third visit do they relax. What should we do? Make house calls?”

“No!” replied the aide emphatically. “They’d suspect you were trying to find out something. Nobody should visit the homes but the people who live in the neighborhood.”

This exchange took place last summer in Denver, Colo. In its setting, the different kinds of staff members present, the search for a way to better rapport between the server and the served, and the professional’s request for guidance from a nonprofessional team member, it illustrates something of the revolutionary approach to the provision of health care for

promoting CHILD HEALTH through COMPREHENSIVE CARE

KATHRYN CLOSE

children being made in many areas of poverty today. The neighborhood clinic in which it took place is part of Denver's project for the comprehensive health care of preschool and schoolage children, one of 58 such projects supported by the Federal Government through the Children's Bureau in low-income areas throughout the country. Multidisciplinary team discussions, including both professional and nonprofessional team members, are common occurrences in such projects. And the invisible barrier between the professional person and clinic patient, sensed by the young doctor, is a problem bequeathed today's service efforts by the indifferent, disconnected services so often encountered by poor people in the past.

The comprehensive health care projects for children, usually called children and youth projects, represent attempts to get away from the fragmented service patterns of the past and to find ways of providing health care geared to the needs of children as whole developing human beings. Established under the 1965 amendments to the Social Security Act,¹ they are based on the assumption—spelled out in the law—that attention to the whole child requires comprehensiveness, accessibility, high quality, coordination, and continuity in both preventive and treatment services. Interpreting comprehensiveness broadly, they are not only providing children with preventive and therapeutic medical and dental care, but are also attempting to deal with the many aspects of the environment that affect a child's health, whether in the home, school, or community—helping mothers get a greater nutritional leverage for their families out of scant food budgets, working with

them on the emotional problems that block good parent-child relationships, conducting group discussions for teenage mothers, putting pressure on landlords to repair defective plumbing or heating equipment, and even, at least in one project, helping the people of the neighborhood organize an egg-buying cooperative.

An observer has predicted that the children and youth projects will have an important effect on the Nation's health.² The reason: the children and youth projects are bringing about changes in methods of providing health care among long-existing services, welding service fragments into a meaningful whole, and establishing new services to fill important gaps. The legal and administrative requirements are flexible enough to allow for experimentation in new ways of reaching children needing attention, of using various kinds of staff members to the patient's best advantage, and of effecting salutary changes in communities as well as in individual families and children.

As demonstrations of methods of health care, the children and youth projects are confined to defined geographic areas predominantly inhabited by the poor—usually several census tracts within the center of a large city, but in a few instances, whole counties or even a combination of counties. While the projects provide medical treatment and hospitalization only to children whose families are considered medically indigent, their preventive services are available to all children living in the target areas.

Under the law, the Children's Bureau may make grants for operating such projects up to June 30, 1972, to State or local health departments, State crippled

children's agencies, schools of medicine, or teaching hospitals affiliated with such schools, the grantee being responsible for 25 percent of the cost. The appropriation for the 58 projects in operation in fiscal year 1969 was \$39 million.

Common characteristics

Although varying in administrative structure and emphasis, the projects share many common characteristics. All but a few are directed by a pediatrician with the assistance of a core multidisciplinary team, usually composed of an administrative officer, a public health nurse, a social worker, a dentist, and a nutritionist, with consultation available from other specialists, such as psychologists, psychiatrists, physical therapists, occupational therapists, and hearing and speech specialists. Through similar multidisciplinary teams—augmented by audiologists, technicians, and various types of nonprofessional aides—they provide preventive, diagnostic, and treatment services in clinics near the children's homes, backed up by the specialty services and facilities of modern hospitals. They reach out to find unserved children by working closely with the schools and other community agencies and follow up on broken appointments through visits to the children's homes. Looking on each child they serve as a whole human being, they attend to the many intermingling aspects of his physical, emotional, and mental condition, providing immunizations, health education, nutritional advice, and parental counseling to keep him well, treating his illnesses, and correcting his defects insofar as possible.

While the projects are pediatric services and so provide medical care only to children and adolescents, they are, for the most part, family-centered pediatric programs. For example, when a child is brought into a clinic for the first time—often for treatment of transitory illness or because the mother is worried about his failure to gain weight—subsequent appointments are made for complete health assessments not only for him but also for all the other children in the family. If the appointments are not kept, a followup visit may be made to the home to find out why and to learn as much as possible about the other children. In many clinics children of the same family are examined by the same doctor. The clinics usually keep family records and arrange for all the children in the family to come in on the same day to save the mother's time. Sometimes the really serious problems in the family turn out to be those of children the mother left at home on her first visit.

Although the children and youth projects do not provide medical care to adults—except in a few places where they are integrated with clinics sponsored by the Office of Economic Opportunity—they focus a great deal of their attention on mothers in an effort to help them strengthen family life and so provide a nurturing environment for their children. They provide or arrange with another agency to provide the service of a homemaker when she is ill, social casework to increase her ability to tackle her family problems, nutritional education and dietary counseling in line with her family's likes and dislikes; and help in applying for public assistance, finding suitable housing in an emergency, or getting medical attention for herself. They also help fathers in similar ways.

For example, a 10-year-old girl who became ill in school with a severe headache and vomiting was taken to a neighborhood clinic of a children and youth project. After examining her the pediatrician asked the nutritionist to make an immediate home visit. The nutritionist learned that one head of cabbage had served as the entire dinner the previous day for the mother, father, and two children, and that the family's only resources were \$5 and some flour and a little bit of milk. The father, a day laborer, had been out of work for 2 weeks because of illness, but was ready to go back. After taking the mother shopping to stretch the \$5 as far nutritionally as possible, the nutritionist taught the mother and daughter how to bake bread. Her friendliness encouraged the parents to take the other child, a little boy, to the clinic where he received a health assessment and badly needed dental care, and where the social worker talked with the parents, helping them to plan ahead to meet future crises and to get enrolled in Medicaid to take care of their own medical needs.

Variations

The 58 projects present a variety of patterns for reaching and serving children and their parents. Each one is to a large degree molded by the characteristics, resources, and needs of the community it serves and, also, to some extent, by the special interests and proclivities of its operating agency, its director, and its staff members.

Thus some projects try to provide some service to every child in the target area and so spend a great deal of effort on casefinding—visiting schools, churches, and other neighborhood organizations and

even sending staff members from door to door in the neighborhood to acquaint people with the services available. Some, in areas where school health services are minimal or lacking, provide visual and auditory screening and even physical examinations to schools, as well as to Head Start programs, in their target neighborhoods. Other projects are concentrating on giving more intensive attention to the families registered with them.

Some projects have set up special clinics for adolescents; others are concentrating their attention on the care of children under 6. A few, impressed by the evidence they see of a tie-in between a child's school experience and his emotional state, have assumed responsibility for helping children with school problems: one provides a "learning clinic" staffed by two psychologists; another, a reading specialist; still another, group therapy sessions for boys suspended from school because of behavior problems.

One project, in a city where the inside walls of many old tenements have undercoatings of lead-based paint—picked off and eaten by many small children—operates a special casefinding and treatment program for children with lead poisoning. Another, in an area where defects in plumbing and heating equipment are common, includes ecologists on its staff to work with families and local authorities to eliminate such hazards to children's health and safety. The latter project also has a staff of home aides, working under a home economist, to help mothers with household management and nutrition. A project in an area inhabited largely by persons of Mexican heritage has hired a social anthropologist to increase the staff's understanding of the strength and meaning of the ethnic customs and study reactions of the families being served; another, in an inner-city area where Puerto Ricans predominate, has instituted compulsory Spanish lessons for the non-Spanish-speaking members of its staff.

A few projects have added occupational therapists to their staffs to observe the motor coordination of children in the clinic's play area, to report noticeable developmental lags to physicians, and to show mothers how to devise play programs that will stimulate their children appropriately. One project has established a developmental evaluation center for the study, treatment, and followup of children suspected of deviating from the norm in mental or physical development.

Five or six projects have put physical therapists on their staffs to work with handicapped children. The other projects usually purchase physical thera-



Mother and clinical nurse watch a health aide weigh a baby in the pediatric clinic of the comprehensive health care project for children at the Mount Zion Hospital, San Francisco.

py, when needed, from their back-up hospitals or elsewhere or secure this service from the States' crippled children's programs.

Dental care

Dental care is required by law of every project. The methods of providing such care vary as does the scope of the care. Many projects have equipped their neighborhood clinics with dental chairs and staffed them with full-time or part-time dentists, dental hygienists, and dental aides.

In Kansas City, Kans., for example, every child registered with the project's neighborhood center is given a complete dental examination with a full mouth X-ray, his teeth are cleaned, his cavities are filled, and recall appointments are made for him at regular intervals. In this center eight part-time dentists rotate in providing treatment; a dental hygienist takes X-rays, cleans teeth, applies topical fluoride and instructs children, in the clinic and in the public and parochial schools in the area, on how to take good care of their teeth; and two dental assistants rotate in helping the dentist and serving as receptionist.

So great is the backlog of dental need among children in the project areas that few projects have been

able to meet all the need encountered. One project, for example, has found that 67 percent of the children registered with it had never been to a dentist. Some projects have been able to offer continuing dental care to selected groups of children only, serving other children only on an emergency basis. For example, in the project at Aurora, Colo., complete continuing dental care with followup is offered only to children who are in the first grade of school at time of registration. Other projects provide dental assessment, prophylaxis, treatment of cavities, and followup to all project-registered children but have been unable to provide orthodontia or dental surgery except in a few cases.

A few projects have enlarged the supervisory staffs of local dental schools and arranged for project patients to be served by the students, interns, and residents. Others have arranged with local dental societies to provide dental care to project patients on a fee-for-service basis. Still others rely on volunteer dentists to augment the services of a small dental staff.

Some plusses

"We do everything a pediatrician normally does in his office—plus," said a physician recently in describing the operations of a neighborhood clinic in a children and youth project. By "everything" he meant that each child coming to the clinic was immunized against communicable diseases and given a complete health assessment, with urinalysis and blood tests and screening tests for tuberculosis and hearing and visual defects; that sick children were treated at the clinic or hospitalized, if necessary; and that arrangements were made with appropriate specialists for further diagnosis and remedial treatment of children with obvious or suspected defects. By the "plus" he was referring to the services of those nonmedical members of the clinic's staff—the public health nurse, the social worker, the nutritionist, and community aides—who look into the child's daily life and try to deal with whatever impediments may be blocking his natural tendency to grow into a healthy human being, whether these are in his mother's ability to understand or follow the physician's directions, the relationships in his family, the condition of his home, his behavior and performance at school, or what he is getting to eat.

The public health nurses visit the homes of new patients to assess health conditions, follow up on how clinic recommendations are being carried out, and counsel the family on general health practices. They

also do individual teaching in the clinics, conduct group discussions in child care for new mothers, especially teenage mothers, and work with nutritionists on self-improvement programs for obese girls. In some projects they also provide health services to the schools in the target neighborhoods.

In most projects, a public health nurse serves as a nurse coordinator to assure continuity of care by providing a liaison between the children and youth clinics, the home, the inpatient department of the back-up hospital, and the hospital's emergency service, where the patients go for treatment of acute illnesses in the night and during weekends when the clinics are closed.

Working different ways in different projects, the nutritionists teach parents the importance of food of the right kind and ways of stretching the family food dollar. They evaluate children's diets and food habits and counsel parents and older children in relation to both normal eating patterns and therapeutic diets for children with nutritional deficiencies, metabolic diseases, or other disorders. They work in the clinics with groups of parents and teenagers as well as with individuals and provide consultation to other staff members such as the nurses and social workers. They reach out to the community with nutrition education, working through the schools and community groups. They also work with individual families in the community, often with the help of dietitians, home economists, and staff aides to teach parents how to shop wisely, obtain food stamps or donated foods when needed and available, prepare and use donated foods, and improve methods of home management.

Like the nutritionists, the social workers function differently in different projects. In some of the smaller projects they try to see every child and mother in a kind of screening interview to determine whether the family needs help with problems. In larger projects they usually see only selected types of patients, for example, teenage unmarried mothers, children referred by the schools because of behavior problems, and mothers facing a family crisis, such as eviction or the breakup of a home.

Some social workers provide intensive casework in selected cases to help parents find the inner strength to cope with their family problems themselves. Others see their service as crisis oriented—being available to help parents and children deal with emergencies whenever they occur.

So many medical problems seen in the pediatric clinics derive from community problems—bacterial

lysentery, rat bites, lead poisoning, to name a few—that some project social workers are beginning to shift their emphasis from casework treatment to prevention by focusing attention on the need for community change.

In Washington, D.C., for example, a project social worker has organized a parents' group that has conducted a neighborhood cleanup campaign and prevailed upon the city authorities to institute a rat control program. Similarly, a social worker in a New York City project has helped organize the tenants of a public housing project to get a family planning service established in the neighborhood.

Community links

The projects lean heavily on nonprofessional aides who reside in the target neighborhoods to break through the cultural barriers between their highly professional staff members and the depressed populations they serve. They employ neighborhood people as social work assistants, community aides, family health aides, nurse's aides, nutritionist's aides, home aides, dental aides, laboratory aides, receptionists, clerical workers, and in a host of other capacities. Some of these aides have been trained on the job, and some in special programs sponsored by community agencies or local community colleges.

Altogether the 58 projects have more than 750 neighborhood aides on their staffs. These aides have become the projects' true link to the community. Being a part of the target neighborhoods, they know what it is like to live in a poverty-stricken community and what prevents families from providing children with the conditions conducive to health. Because they speak the local language—figuratively and literally—they often have a better entree to a family's home or confidence than the somewhat exalted professional person and a more realistic understanding of how the family might react to clinic recommendations.

A nutritionist's aide, for example, when asked to comment on a doctor's instructions on baby feeding for new mothers immediately objected to the statement, "Discard any formula left in the bottle after the baby has finished feeding." Said she: "These mothers will be shocked at the idea of throwing food away. Better say: 'Don't give any leftover formula to the baby again.' Maybe the mother will drink it herself."

Another aide warned against the use of the word "carbohydrate" in connection with the baby's food.

saying she had looked the word up in the dictionary and found it defined as "starch" or "sugar." Pointing out that many women from the South eat laundry starch, particularly during pregnancy, she asked, "You don't want the mothers to put starch in the baby's formula, do you?"

Still another commented: "Mothers don't know what you mean by *scald*. Say *boil*."

In many projects the community aides are recognized as important members of the service team. They follow up on broken appointments, acquaint families with community resources, learn about conditions in the home, and keep the project informed about what is going on in the neighborhood. In some projects, as at the Mount Zion Hospital in San Francisco, they attend all team conferences with the staff members, who pay careful attention to their reports: a mother "talks about illness and death all the time" but pays no attention to her adolescent daughter's complaints of headaches and heart pains; an unmarried expectant teenage mother wants to keep her baby but refuses to register at a prenatal clinic "because she wants to be considered as a person, not a case"; a young mother used up a month's supply of readymade formula in a week because "she fed it to all four of her children when she ran out of

A speech therapist working with a child in a comprehensive care clinic of the Children's Hospital in Washington, D.C.



food"; an irate mother complained to the school about a teacher's treatment of her child and "that just made things worse."

The community aides also perform an important function in making the project's services known to the community and in finding families that need the project's help.

In Denver, for example, a community aide learned of an 18-month-old child who still could not walk. She helped the fearful, distraught mother, who could not speak English, take the child to a clinic of the children and youth project. When a thorough physical and medical examination showed that there were no organic difficulties, the clinic's public health nurse went into the home with a Spanish-speaking practical nurse. The home situation proved to be rife with tensions stemming from the autocratic behavior of the father. After a conference between the public health nurse, the social worker, and the nutritionist, arrangements were made for the practical nurse to visit the home regularly to teach the mother English while helping her to learn how to give the baby appropriate care and stimulation, to feed her children nutritiously, and to find ways of breaking down the father's resistance to getting the other children to the clinic for care.

Revolutionary methods

The projects vary in complexity, depending on the size of their "target" areas, the sophistication and nature of available resources, and the attitudes of local professional organizations toward them. Some large cities, for example, Chicago and Denver, have one project covering several target areas and involving the participation of several hospitals and "satellite" or neighborhood clinics. Others contain several unconnected projects, each with its own target area—as do New York and Baltimore. One city, Philadelphia, is unique in having five separate projects operated independently but planned together by the professors of pediatrics of the city's five medical schools and closely coordinated by the project directors and staff.

In some areas, as in Kansas City, Mo., children and youth projects that are hospital administered have been integrated into the hospital's pediatric clinic, the new elements being the accent on comprehensiveness and continuity provided by the use of interdisciplinary teams, the family-centered approach, the provision of well-child supervision in addition to treatment services, the followup of

broken appointments, the provision of outreach services such as visual screening and nutritional education in the schools, and the development of a close working relationship with community agencies such as the community action program, a visiting nurse service, or a social casework agency. Some hospital directors of pediatrics say that by introducing such concepts the children and youth projects have revolutionized their hospitals' methods of care.

At the Children's Mercy Hospital in Kansas City, Mo., the project has added staff members to the Visiting Nurse Association and the school health program of the local school system as well as to the hospital's pediatric service. It regularly brings representatives from these and other community services such as the juvenile court probation department to its interdisciplinary case conferences.

"The big thing about the C and Y project that has permeated the hospital," a member of the project team has remarked, "is the coordination. The services were there before, but they didn't know about each other."

One voluntary hospital in another area was a white island in the midst of a black neighborhood until it began planning an application for a project and so had to look into the resources in the neighborhood. It now has black representation on its governing board as well as on its medical board. The staff of the project is predominantly black, with both professional and nonprofessional employees coming from the immediate neighborhood.

Learning how to work with members of other professions has been described by more than one project director as the most difficult, but rewarding, aspect of a children and youth project. Learning has been slower in some projects than in others because some staff members have not had previous experience in working with members of other disciplines. But in many projects, various members of the clinic staff function almost as a unit, looking together at all aspects of the patient's condition, planning together for meeting his health needs, and deciding together which team member shall carry responsibility for following through on the plan.

For example, at the Roosevelt Hospital in New York where the project's target area is divided into two parts, each part is served by a team called a "module" composed of a public health nurse, a social worker, and a nonprofessional person trained by the project as a "physician's assistant." These teams meet daily to devise a case plan for patients seen the preceding day at the clinic. Other members of the project

staff, such as the nutritionist, otolaryngologist, dentist, psychologist, or consultant psychiatrist, attend these assessment conferences, when appropriate, as do members of outside agencies, especially the guidance counselors from schools in the target areas. In all cases, however, the pediatrician who examines the child assumes total responsibility for the health care plan adopted. The project has found that including the school counselors in these assessment conferences not only brings valuable information about the child under discussion to the team, but also expedites the team's recommendations concerned with the child at school more effectively than the usual written communications between clinic and school.

Team conferences are also held on each child registered with the children and youth project at the Jefferson Medical College in Philadelphia. There the project has developed a generic interviewing instrument called a continuing care interview and has trained each team member in its use. Before any comprehensive plan is devised for a child, one of the team members interviews the child's mother, using this interview design, and then prepares a summary of the apparent assets and liabilities of the child and his family and outlines a tentative long-term plan for the child's preventive health care, which he presents to a conference of the entire team along with the results of the child's physical examination. In the ensuing discussion, the team develops a revised plan. The revised plan is later submitted to the child's family in a conference attended by the original interviewer, the pediatrician, and the specialists who would be primarily involved in carrying it out, where it may undergo further revision according to the family's interest. The staff members who attend this family conference become the family's primary care group, the persons responsible for continuity of care.

Some impressions

A visitor to these projects cannot help but become acutely aware of the many community problems complicating their efforts to improve children's health—

the meagerness of family incomes; the lack of decent housing in the neighborhoods being served; the long waiting lists at mental health clinics; the overcrowded, inadequately staffed schools; and the lack of day-care and homemaker services to relieve overburdened mothers. It is depressing to hear from a clinic director, for example, that the exceptionally good clinic attendance on the coldest days of winter may be due to the lack of heat in the families' homes.

Nevertheless, the visitor catches a sense of excitement among the people of the many professions and talents who are working together to provide total, continuous, health care to children. Apparently derived from participation in a creative experience, the excitement radiates from all types of project staff members, from directors to community aides.

One also finds evidence of enthusiasm among the people the projects serve. It is shown in the activities of parents of the children in care—of those who are participating in clinic-sponsored parents' councils to mobilize neighborhood efforts toward community improvement; of those who babysit for other mothers while they take their children to the clinic; of those who give their time in the clinic or the community as volunteer aides, supervising a play area in the clinic waiting room, assisting in mass screening programs, or knocking on their neighbors' doors in casefinding efforts. It is reflected in the "Clinic and Community Caller," a newsletter with the folksy quality of a small town newspaper, put out by the parents of children enrolled in one of the neighborhood clinics of a Baltimore project. And it comes through in numerous spontaneous comments, such as the one made by a project patient's grandmother who sighed:

"I only wish I had had this kind of care for *my* children."

¹ Section 509, Title V, Social Security Act, as amended by P.L. 89-97, 86th Congress.

² Weckworth, V.: Efficiency versus effectiveness: how these interact in the administration and allocation of funds for health care. Systems Development Project, School of Public Health, University of Minnesota, Minneapolis. Comment Series No. 7-8 (1), On Allocating Resources: PPBS. March 1967.

a
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at

THE COURTS and CHILDREN'S RIGHTS

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● For more than a decade, the United States has been witnessing a revolution in judicial concern for protection of the rights of the individual. In the field of criminal law, this concern has been expressed in court decisions establishing the right of an accused person to be represented by counsel in major cases, if necessary at public expense; placing limits on the State's power to conduct searches and seizures to obtain evidence; confirming the right to a speedy trial; and generally reinforcing the constitutional privilege against self-incrimination at various stages of legal proceedings on criminal charges. Although the juvenile court at first stood still in the face of the sweeping changes in the adult criminal courts resulting from these decisions, it was inevitable that some form of protection would eventually be provided to the child brought before the court designed to serve him.

The most notable steps in this movement to protect an accused child's legal rights have been made in the past few years by the Supreme Court of the United States through decisions dealing with delinquency proceedings in juvenile court, particularly in the Gault case¹ in 1967. In the Gault ruling, which holds that due process of law must be observed in juvenile proceedings, the Supreme Court found it necessary to protect the child from the very institution that had been set up to provide him with humane treatment when he is in trouble with the law.^{2, 3}

The movement to protect individual rights has also reached far beyond the criminal law. In civil courts, a tendency to hear suits charging invasion of privacy or the intentional or negligent inflicting of emotional harm to another person illustrates the increased recognition of concern for protection of highly valued personal interests. In noncriminal actions dealing specifically with children, the courts have increasingly been concerned with protecting children against abuses, which may occur almost as a byproduct of laws specifically enacted for the orderly establishment, continuance, and dissolution of the family. In a sense, this concern for the protection of children in civil action is consistent with the premises of the Gault decision, which sought to protect the child against abuses in the juvenile court.

The juvenile court ostensibly derives its broad powers from the amorphous—and, some would say, false—concept of *parens patriae*, under which the State, through the juvenile judge, acts as a “good parent.” In many cases in which the State takes this role, objections could be raised against either the process or the result. If this is so, is there not a need for protection of the child in some instances against his parents as well as against juvenile court judges?

To continue this analogy, the family is in fact a governmental as well as an economic and social unit. Parents have almost unlimited authority over their minor children, subject to certain established

State requirements, such as vaccination and minimum school attendance. Although parents are required to support their children, the courts enforce this obligation only in extraordinary circumstances or in flagrant cases of nonsupport. That some parents use their power in despotic fashion has become obvious and has led to the enactment of statutes in all the States to protect children against intrafamily abuse, a subject extensively discussed in previous issues of CHILDREN.⁴⁻⁸

Justification of the continued existence of the family as it is known today is frequently based on its role as the most effective unit for the procreation and training of children, as well as its role as a governmental unit *per se*. Just as the juvenile court is "for" the child, so then is the family. And so, theoretically, are the various laws that surround the creation and dissolution of the family, or that provide sanctions against procreation of children outside the particular marriage unit licensed by the State. This analysis is not intended to deny a spiritual or emotional basis for marriage, nor to imply that marriage is simply a license to breed. But in the view of our laws today, marriage is a civil institution; therefore, the child's position in the family must be considered in that context.

Before examining some recent instances in which the courts have intervened to protect the rights of children, as well as several areas where intervention seems likely to occur in the near future, it is necessary to explain why no major judicial movement to protect the rights of children occurred until recently. Regulation of marriage and the family for a long time was considered a cherished right of the States, in accordance with the reserved powers clause of the 10th amendment to the Constitution of the United States. Although this should not have been taken to mean that such Federal constitutional guarantees as due process and equal protection were wholly inapplicable to State regulation of the family, in practice the courts were reluctant to permit attacks based on such grounds. Federal courts even announced that they did not wish to exercise jurisdiction over suits that chiefly involved issues of family law.

However, recent decisions of the U.S. Supreme Court, as in the Griswold case⁹ (which invalidated a State proscription against use of contraceptives by married couples) and the Loving case¹⁰ (which set aside a State statute outlawing interracial marriage), have finally made it clear that State action dealing with the family can be challenged successfully in the

courts on constitutional grounds. This judicial climate of concern for individual rights generally and of willingness to apply Federal constitutional limitations to State regulation of the family provides the opportunity for better delineating the boundaries of children's rights and broadening the legal avenues for the protection of those rights.

Illegitimacy

One of the most substantial breakthroughs in judicial action to protect children's rights concerns the status of the child born out of wedlock. Although in general State laws have not dealt with children born out of wedlock as harshly as did the English common law, the arbitrary status of illegitimacy has nevertheless affected the child's inheritance rights as well as the obligation of the father for child support. Legislative attempts to ameliorate the hardships of the status of illegitimacy for a minor child have largely followed a pattern of trying to reduce the number or percentage of children deemed illegitimate instead of eliminating the status itself. Some very early State laws provided that the child of a void or voidable marriage would be legitimate, even though an annulled marriage is regarded as never having been performed. In 1792 a Virginia law eliminated the illegitimate status of children born out of wedlock whose parents later marry each other. Some States provided for the legitimation of a child born out of wedlock through the father's acknowledgment of paternity. However, in many States the child born out of wedlock but subsequently acknowledged without intermarriage of the parents is still generally accorded fewer rights than the child born in marriage. Discrimination against such children is particularly prevalent with regard to inheritance rights.

In 1968 the U.S. Supreme Court in the Levy case¹¹ squarely faced the problem of whether one type of State discrimination based on illegitimacy could be maintained constitutionally. The administratrix of the estate of five minor children born out of wedlock brought a suit for damages based on the death of their mother, who had been their source of support. The Louisiana appellate court¹² held that under Louisiana civil law only children with legitimate status could bring such an action, but the U.S. Supreme Court overruled this decision on the ground that classification by birth status for this purpose violates the equal protection guarantees of the 14th amendment. In a companion case,¹³ the Supreme Court held that under Louisiana law a mother could

bring a suit for damages based on the wrongful death of her illegitimate son.

The fallout from the Levy decision already can be detected around the country. A Missouri appellate court has relied on this decision to invalidate the part of the State's support laws that distinguished between legitimate and illegitimate children.¹⁴ A New York court has questioned a support procedure in its relatively new Family Court Act¹⁵ that discriminates on the basis of legitimacy. The Maryland Court of Appeals has used the decision in ruling that a child born out of wedlock cannot be removed from the home of his mother solely on the basis of the birth of her second illegitimate child or another illegitimate pregnancy.¹⁶

Some courts, however, have sidestepped applying the Levy decision in cases in which they deem classifications based, partly at least, on legitimacy to be rational.¹⁷ Therefore, the full impact of the Levy decision remains yet to be determined. One of the reasons most frequently given for continuing to distinguish between legitimacy and illegitimacy is the desire to punish parents for conduct that leads to the birth of children out of wedlock. It is exactly this approach, which subordinates the interests of the individual child to the system generally, that was specifically condemned by the Supreme Court in the Levy case.¹⁸

Another decision of the Supreme Court in 1968 followed the theme of protecting children's rights when the validity of the Alabama welfare department's "substitute father" rule was challenged.¹⁹ The children involved had sought to enjoin the State from cutting off payments to them under the program of aid to families with dependent children (AFDC) because of the alleged immoral conduct of their mother with a man not their father.

The Supreme Court noted that protection of children was the paramount goal of AFDC and, therefore, the children's interests were not to be sacrificed

because of their mother's impropriety. In short, although the State might have the power to remove the children from their home if they were in fact neglected, the children's rights under AFDC would be protected while they remained with their mother.

Divorce proceedings

Divorce is an area in which procedures are urgently needed to protect the interests of the child more effectively. In the past, divorce often carried strong overtones of immorality; today it is viewed in most States as a social tool that is desirable in many circumstances—so long as its impact on the minor children of the marriage can be minimized. Some courts are showing concern for saving marriages in fact, rather than simply in name, through increased use of social devices such as family counseling. Usually priorities for counseling in divorce cases are given to parents with minor children. In some courts such counseling is required.

The child may need formal protection either in the divorce proceeding itself or in the preceding negotiations of financial and custody agreements that are reached after hard bargaining. Divorces that are not contested often involve "quickie" proceedings in which the judicial role may be little more than a perfunctory listening to the required corroborative witnesses and a ratifying of previous agreements made by the spouses. Even in contested proceedings the presentation of evidence and control of the case are generally in the hands of attorneys for the husband and wife, both of whose interests may be adverse to those of the children of the marriage on such issues as whether to reveal past instances of mishandling or neglect that might disqualify either parent as a proper guardian.

Recently, many judges—particularly those in family courts—have begun to obtain and use independent custody investigations in both contested and uncontested divorce proceedings. This trend reflects judicial concern that custody and support awards should be based on the best interests of the child rather than simply on a mechanical rule for allocation according to the sex or position of the spouses or on a rubber-stamp agreement made by the parents in negotiations where the child was not represented. In using an independent custody investigation, the judge recognizes that if provision for the child is simply an item thrown into the parents' negotiations, the child may be bartered for various concessions having nothing to do with his personal welfare. The investigation

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also assures the judge that he has information about important disabilities or problems of the parents relevant to the custody award.

Courts in some States have even gone beyond requiring an independent investigation and have provided separate legal counsel for the child in a divorce action. This practice raises some questions, such as whether a child's counsel should be permitted to introduce evidence of recrimination or collusion that would affect the case or to contest a divorce award as being against the child's interests. However, separate counsel—even when not given such latitude—can serve the valuable function of assuring that the child's rights are not lost in the presentations of the parents' counsels.

Providing independent counsel for the child, however, by no means obviates the need for the court to provide for impartial custody investigation. The combination of these two practices can bring to the court the facts necessary to prevent the interests of the child from being overlooked.

Wrongful life

No doubt the most dramatic attempt to secure protection of a child's rights through the judicial process came in the Zepeda case in Illinois in 1963,²⁰ in which a child literally sued his father for having caused him to be born out of wedlock. After citing laws showing the State's great concern for mitigating the hardships accompanying illegitimate status, the State court concluded that the child had in fact suffered a wrong through his father. Although the court called this wrong a tort, it declined to take the next step—to permit an award of damages without specific legislative authorization—because of the tremendous implications of such a step.

The theory of the Zepeda decision has been asserted in several other jurisdictions since 1963, and its possible influence toward change does not appear to be spent. A New York State court²¹ used the rationale of the Zepeda ruling in refusing to dismiss the damage suit against the State of a child produced by the rape of a mental patient in a State institution, but this decision was overruled by a higher court.²²

In another jurisdiction, parents were unsuccessful in suing a physician on behalf of themselves and their defective child.²³ In this suit, which has been discussed in terms of a "right not to be born," the court rejected the argument that the parents might have obtained an abortion if they had been fully apprised of the fact that the German measles suffered

by the mother during pregnancy might produce defects in her child.

In short, the judicial attitude in this group of cases to date has been one of "better bred than dead." However, the existence of the cases indicates the extent to which lawyers are now willing to assert the rights of children before the courts.

Other civil actions

Although in many circumstances a child may now sue his parent in a breach of contract or other action affecting his property, there remains a general policy of parental immunity from suit for personal injury inflicted by the parent on his child. This is beginning to give way to some degree, especially in instances in which such an action will not be considered destructive to family harmony. For example, in an automobile accident in which a child might sue his parent for negligence, the latter would be indemnified through insurance. The same arguments that were used a few years ago to oppose damage suits between husbands and wives—including the possibility of collusion—are being used to oppose suits of children against their parents. However, support is growing for the idea that parent-child immunity from lawsuits should be almost wholly abolished, perhaps leaving some leeway for the exercise of parental discipline.

Courts in Illinois, Michigan, and Minnesota also have permitted children to bring actions for damages against third parties who disrupted the family home by alienating the affections of one of the parents. Other State courts have denied hearings in similar actions on the ground that the legislature, not the judiciary, should create an important policy—a philosophy similar to the court's in the Zepeda case.

What next?

This has by no means been an exhaustive listing of the areas in which courts have begun to show increased interest in protecting the rights of the child, or of the situations in which such expressions are next likely to appear. In many areas, such as the freedom to express opinions, there seems little question that the child is accorded the same basic rights as the adult. For example, a recent Supreme Court decision upheld the right of schoolage children to protest the Vietnam war in a nondisruptive fashion by wearing black armbands, despite a contrary regulation by school authorities.²⁴

Neither the cases cited nor the indication of more to come necessarily means a massive flood of litigation will ensue to tear apart existing family law. Instead the current trends illustrate a growing judicial awareness of the need for legal changes affecting the family, with a focus on protection of the child's interests. Some courts have already felt the need so keenly that they have taken necessary corrective measures in the absence of legislation, while others have chosen to prod the legislatures to act first. In any event, recent actions of the courts should give greater impetus to the general reform movement.

¹ *In re Application of Gault*, 387 U.S. 1, 87 S. Ct. 1428 (1967).

² Brown, H. G.: Juvenile courts and the Gault decision: I. Background and promise. *Children*, May-June 1968.

³ Downs, W. T.: Juvenile courts and the Gault decision: II. An invitation to innovation. *Children*, May-June 1968.

⁴ Morris, M. G.; Gould, R. W.; Matthews, P. J.: Toward prevention of child abuse. *Children*, March-April 1964.

⁵ Wasserman, S.: The abused parent of the abused child. *Children*, September-October 1967.

⁶ Ireland, W. H.: A registry on child abuse. *Children*, May-June 1966.

⁷ Johnson, B.; Morse, H. A.: Injured children and their parents. *Children*, July-August 1968.

⁸ Paulsen, M.: Legal protections against child abuse. *Children*, March-April 1966.

⁹ *Griswold v. Connecticut*, 381 U.S. 479 (1965).

¹⁰ *Loving v. Virginia*, 388 U.S. 1 (1967).

¹¹ *Levy v. Louisiana*, 391 U.S. 68 (1968).

¹² *Levy v. Louisiana*, 192 So. 2d 193 (La. App. 1967), cert. denied, 250 La. 25, 193 So. 2d 530 (1967).

¹³ *Glonn v. American Guarantee and Liability Insurance Co.*, 391 U.S. 73 (1968).

¹⁴ *R—— v. R——*, 431 S.W. 2d 152 (Mo. Sup. Ct. 1968).

¹⁵ *Storm v. None*, 57 Misc. 2d 342, 291 N.Y.S. 2d 515 (Fam. Ct. 1968).

¹⁶ *In re Cager*, 248 A. 2d 384 (Md. 1968).

¹⁷ *Baston v. Sears*, 15 Ohio St. 166, 239 N.E. 2d 62 (1968).

¹⁸ Krause, H. D.: Legitimate and illegitimate offspring of *Levy v. Louisiana*—first decisions on equal protection and paternity. *The University of Chicago Law Review*, Winter 1969.

¹⁹ *King v. Smith*, 392 U.S. 309 (1968).

²⁰ *Zepeda v. Zepeda*, 41 Ill. App. 2d 240, 190 N.E. 2d 849 (1963), cert. denied, 379 U.S. 945 (1964).

²¹ *Williams v. State*, 46 Misc. 2d 824, 260 N.Y.S. 2d 953 (Ct. Cl. 1965).

²² *Williams v. State*, 18 N.Y. 2d 481, 276 N.Y.S. 2d 885 (1966).

²³ See *Gleitman v. Cosgrove*, 49 N.J. 22, 227 A. 2d 689 (1967).

²⁴ *Tinker v. Des Moines Independent Community School District*, 85 S. Ct. 733 (1969).

. . . development of a far broader range of alternatives for dealing with offenders is based on the belief that, while there are some who must be completely segregated from society, there are many instances in which segregation does more harm than good. Furthermore, by concentrating the resources of the police, the courts, and correctional agencies on the smaller number of offenders who really need them, it should be possible to give all offenders more effective treatment.

A specific and important example of this principle is the Commission's recommendation that every community consider establishing a Youth Services Bureau, a community-based center to which juveniles could be referred by the police, the courts, parents, schools, and social agencies for counseling, education, work, or recreation programs and job placement.

The Youth Services Bureau is needed in part because society has failed to give the juvenile court the resources that would allow it to function as its founders hoped it would. In a recent survey of juvenile court judges, for example, 83 percent said no psychologist or psychiatrist was available to their courts on a regular basis and one-third said they did not have probation officers or social workers.

"The Challenge of Crime in a Free Society," a report by the President's Commission on Law Enforcement and Administration of Justice, February 1967.

two child psychiatrists, a pediatrician, and a social worker consider the meaning of . . .

INFORMED CONSENT in

PEDIATRIC RESEARCH

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In recent years, several exploratory studies of conflict between research and social values have been carried out. Some of these studies have been focused on behavioral research;¹⁻³ others, on certain nonbehavioral aspects of pediatric research.^{4,5} In pediatric research the principle that "informed consent" must be obtained from the parents of the child who is a research subject, and, where appropriate, from the child himself, has become accepted as an ethical necessity. The question, however, remains as to the *meaning* of informed consent in the context of pediatric research. Herein lie some difficult issues.

The purpose of pediatric research is to clarify problems in understanding normal and pathological processes and in the diagnosis and treatment of disease. Such research has the ultimate goal of benefiting individual children, even though the child who is a research subject may derive no benefit from it.

When and to what extent is subjecting a child to pain and anxiety justifiable? A simple guideline might be: When there is no possible benefit to the child, then any procedure that harms the child in any way is categorically unethical. What constitutes "benefit" and "harm" of course remains to be defined in the individual case. Moreover, this guideline leaves unresolved the question of the conditions under which

the parent has the right to give consent for research to be performed on his child when the research cannot help the child but holds out promise of great good for many other children. The fact is, there is no simple guideline.

Some medical writers have approached this question in a general way by suggesting some preliminary considerations—such as the design and value of the research and whether, if it has been done before, it is worth repeating—to be followed by an evaluation of the physical and psychological risks for the child. Psychological hardship for the child, sometimes amounting to trauma, may be caused by many factors, such as the nature of the specific research procedures, the child's separation from his mother, changes in the child's environment, and possible shifts in family relationships or intensification of conflict in the parents' feelings about a defective child.⁶

The nature of "informed consent" has also been approached in a general way. For example, a declaration adopted by the Council of International Organizations for Medical Science states:

If at all possible, consistent with patient psychology, the doctor should obtain the patient's freely given consent after the patient has been given a full explanation However, the responsibility for clinical research always remains with the research worker; it never falls on the subject even after consent is obtained.⁷

And a report of the British Medical Research Council states:

By true consent is meant consent freely given with proper understanding of the nature and consequences of what is proposed. Assumed consent or consent obtained by undue influence is valueless and, in this latter respect, particular care is necessary when the volunteer stands in special relationship to the investigator, as in the case of a patient to his doctor, or a student to his teacher In general, the investigator should obtain the consent himself in the presence of another person.⁸

The value of such statements is limited by their lack of specificity. They also fail to mention a further general but important concept: Truly informed consent cannot be confined to a single moment in time; it is a continuous process, subject to modification and even at times withdrawal, depending on changes in the conditions of the subject and the research.

Some relevant issues

Investigator's awareness. Several perplexing issues confront the investigator as he seeks to obtain informed consent from the subject.

1. Because advancement on a medical faculty today largely depends on demonstrated productivity in research, a sense of urgency may subtly influence the investigator's presentation of his proposed studies. An investigator needs a high level of self-awareness, as well as integrity, to determine the degree to which his studies serve the needs of children as distinct from his own needs for advancement.

2. Distinguishing the study aspects that might be expected to benefit the child directly from those that may only benefit other children in the future is often difficult. Because it is easier to discuss with a parent a research protocol that will result in direct benefit to the child involved, an investigator may perceive benefits in his research that may not so readily be perceived by physicians unconnected with the study.

3. When the research is concerned with a rare condition or a little-tried therapeutic agent, the basis for a complete assessment of physical risk may be inadequate. Assessment of psychological risk may offer even greater difficulty, since the investigator may have had little training in this work.

4. Effective communication with the child or his parent may not occur. Even the most conscientious and thorough presentation of the purpose of the research and the procedures and risks involved may be insufficient; the reactions of the child or his par-

ents during the explanation must be understood. A careful interview technique is required for perceiving symptoms of an anxiety that may be preventing the subject from hearing, understanding, and remembering the facts being explained to him. Training in such interviewing has seldom been a part of the investigator's preparation.

Involving the child. Can one ever have the truly informed consent of a child? Most investigators make a judgment as to how much information to convey to a child and how much consent to expect from a child. The factors that are usually weighed include the child's age and developmental stage, his level of anxiety, and the degree of emotional support he receives from his parents.

Schoolage children should in some instances be involved in the consent procedure. However, children, as well as adults, need time to comprehend and accommodate to a research plan and procedures. This means that much of the protocol and much of the consent must be broken down into assimilable parts with the investigator making his judgments at many stages during the research.

Parental consent. The final responsibility for giving consent rests with the child's parents or guardian. However, many factors interfere with their capacity to give truly informed consent. Their lack of medical background limits the ability of many parents to understand the nature, aims, and methods of the proposed research, or the possible benefit to their child. Their anxiety about their child and their expectation that research implies "using" the child as a "guinea pig" may further limit their capacity to assimilate explanations. Moreover, they may see no alternatives to consent. For example, some parents regard the suggestion that their child be hospitalized as a research subject as confirmation that the child is seriously ill and may therefore feel that they will be doing the child a disservice if they do not comply. Some parents are prepared to give consent to a trial therapy but feel the therapy will only be made available if they consent to a broader research protocol.

The enticement of obtaining free medical care for the child because he will be participating in research may influence the parents' decision. Conversely, some parents feel less in control of the situation, and more anxious, when they are not required to pay a fee.

Parents are not always aware of the potential psychological stress the procedures may impose on their child. An occasional parent in consenting to the re-

search may be acting out unconscious hostile wishes against the child or may be influenced by anxiety, guilt, and depression. Ethically, the child should not be regarded as the property of the parent to be used as a means to the parent's ends, but should be approached as an individual person with his own specific needs and anxieties.

A parent may ask himself, or may be requested to ask himself: "Are the research procedures that are being considered for my child the kind I would consent to have performed on myself as a child?" This question, however, does not provide a true test of informed consent for the following reasons: (1) neither the parents nor the physician may comprehend the psychological issues involved in consent for oneself; (2) the needs and anxieties of a child are different from those of an adult, and, in some instances, the child cannot speak meaningfully for himself, either about his anxieties or about the proposed research; (3) in considering only his own feelings about the procedures, the parent may be regarding the child as his property rather than as another human being with needs and feelings of his own.

Parental consent, therefore, cannot be regarded as "informed" until parents have had time and opportunity to understand the nature of proposed research, their feelings and attitudes about it, its relevance to their child's medical needs, and its physical and psychological risks in relation to their child's stage of development and personality structure; and to consider alternative sources of appropriate medical care.

A few brief case examples will illustrate some of the complexities involved in the meaning of informed consent. They are presented with the parents' permission and, in one case, the adolescent child.

Changing meaning

The following case illustrates how the meaning of informed consent can undergo changes when uncertainties about the risks of therapy create anxiety in both the patient and the parents, resulting in a weakened sense of trust in the investigator.

A 14-year-old girl who had a brain tumor partly removed at the age of 4 had been under the observation of a pediatric endocrinologist for 2 years. She and her parents became increasingly concerned because of her lack of adequate growth and sexual development. Her delayed development was producing serious psychological and social difficulties for her. Therefore, the parents urged the endocrinologist to consider treating the girl with growth hormone.

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The endocrinologist pointed out that growth hormone was available for therapy only in research, thus necessitating the acceptance of a research regimen for the patient and that its use might be associated with some danger since the few data that were available indicated that it might enhance tumor growth. He explained that because of the risk of tumor growth, he was reluctant to institute the therapy until he could obtain more information from colleagues around the country. The parents had understood from the patient's pediatrician and neurosurgeon that the growth hormone therapy would be appropriate and would involve little risk. Therefore, the delay in instituting the studies engendered mounting anger and anxiety in the family.

When the endocrinologist felt assured that the risk of tumor regrowth was small, he again reviewed the plans for study with the patient and her parents, and arranged for her admission to a pediatric research center.

In this conference, the patient and parents had given formal consent. However, in the preadmission interview with the research center social worker, the parents showed evidence of a marked increase in anxiety. This was expressed in several ways. They seemed angry with and mistrustful of the endocrinologist, with whom they had previously had a good relationship. They complained of his style of communication, apparent reluctance to proceed, and lack of clarity about the procedures involved in the research. They indicated their inability to comprehend the protocol because of its highly technical language. They indirectly expressed fears that their child might die as a result of the treatment, and they reported personality changes in her that they thought reflected either a breakdown in her ability to cope with difficulties or brain changes associated with tumor regrowth. The

mother feared that her own psychological integration might be compromised if things did not go well for her child.

At the request of the investigator the patient was examined by the child psychiatrist. She proved to be a bright, somewhat compulsive girl, who was able to express her feelings vividly. During her first week in the hospital, she described feelings of moderate bewilderment and said that she had "never felt so nervous" in her life. She was particularly afraid "for some unknown reason" of having a glucose tolerance test. Gradually the reason for this particular focus of her fear became known. The investigator had at one time expressed uncertainty as to whether the test would be performed. Now the patient wondered whether she was being made a guinea pig. This set off a chain of other fears. Would she get sick? Would the hormone make the tumor grow? Would she then die? How safe was she, and who would take care of her? Would her mother stay with her? Would the hormone help her? She doubted the good judgment of her parents because she knew they did not know exactly what to expect.

Afraid of the research, this patient was at the same time afraid that she would lose her friends because of her small size, lack of development, and disinterest in such feminine preoccupations as clothes. She also felt unable to meet her parents' academic aspirations for her. Her depression, fears, and anxiety not only made her unable to ask the investigator questions but also led to a helpless compliance.

Soon after the patient's admission to the hospital more data on the growth hormone became available, confirming the assumption that its use carried few risks. This information, plus the genuine concern demonstrated by the endocrinologist, helped the parents reestablish their previous trust in him and made for a much smoother hospital course for the girl.

In this case, the investigator's task of assuring that the consent to the research was made on a truly informed basis became difficult because the procedures contemplated involved risk but no guarantee of gain for the child, thus creating anxiety in both parents and child.

The meaning of the parents' consent underwent several changes that reflected an increase in anxiety and concomitant distortions in judgment. Although highly intelligent, the parents could not understand the protocol outlining the clinical procedures that would take place, primarily because of their anxiety.

The 14-year-old patient was capable of a great deal of understanding and clearly benefited from the psy-

chiatrist's help. However, because of the suppressed anxiety she was experiencing, her initial consent was less meaningful than it appeared. When she was confronted by the reality of the procedures, increasing anxiety altered her perception of the research.

Thus, a succession of attitudes may occur. Initially, the child may feel anxious about the proposed research. However, before he has been confronted with any of the actual procedures, he may find it easier to deny his anxiety and so consent to the research. As the research approaches, his level of anxiety may rise, thus weakening his consent and perhaps leading to a wish to retract. Once the first procedures are completed, the patient's anxiety may abate, changing once more the meaning of his consent.

The child's interests

While the parents and investigator may have a contractual agreement based upon apparently informed consent, it does not follow that this consent is necessarily in the child's best interests. In some instances psychiatric evaluation of a child's capacity to cope with the hospitalization may be indicated before admission. These points are illustrated in the following case.

Research procedures were suggested for a 7-year-old extremely obese, short girl to rule out the possibility of a brain tumor or other organic disease and to establish whether treatment with growth hormone was indicated. The parents gave their consent after the investigator had carefully gone over the complex technical research protocol with them. However in the preadmission interview with the social worker they showed signs of being seriously confused and anxious about the procedures. They feared that lethal air bubbles would result from the intravenous infusions or brain damage from the electroencephalogram. Their consent, obviously not "informed," seemed based on the expectation that if the child gained weight without growing she would become unable to move and would develop dangerous heart disease.

Because these parents described their child as enuretic and prone to night terrors and temper outbursts, suggesting that she might be overwhelmed psychologically by the studies, a child psychiatrist was asked to evaluate the child prior to admission. The social worker held several interviews with the parents to clarify their fears and misconceptions.

Their daughter, Alice, a child of above average intelligence, understood that the doctors "might" be

able to find something to help her grow, but she definitely did not want to go into the hospital. However, she said that if there were not "too many needles" and if she did not feel them too much, she would go into the hospital for the 17 days required. She dealt with her anxiety through an obsessional accounting of the procedures to be followed in the hospital. She told the psychiatrist she wished her parents would stop talking about the hospitalization and would "hurry up and get it over with." On the whole, she showed good judgment and an ability to cope with stress.

Because the physician-investigator was concerned about the possibility of a brain tumor and because the family was under considerable stress, the psychiatrist recommended that the child be admitted to the hospital as soon as possible. A plan for collaborative supportive care between the social worker and the psychiatrist was carried out during and after hospitalization.

Here, the initial consent of these parents was meaningless because of their emotional disturbance, but the child was able to understand the nature of the research, and was further prepared for it by the child psychiatrist. This preparation was especially important because of the urgent medical indication for proceeding.

Special arrangements

In some instances, it may be important to design a therapeutic nursing regimen before hospital admission to safeguard the child's psychological integrity, as in the following case.

A mother gave consent for hospitalizing her 7-month-old infant son, David, for study and surgery. The child had Cushing's disease, a serious endocrine disorder. The hospital regimen would include motor restraint on a metabolic mattress—a device for collecting feces and urine—thus subjecting the child to the risk of social isolation.

David had reached that developmental stage in which children are wary of strangers and so was particularly vulnerable to intense separation anxiety. However, his mother, who was attending school, maintained that she could make only brief evening visits to him a few times a week during the proposed 2-month hospitalization period. She had already turned most of the daily tasks of the child's care to her own mother. David's urgent need for medical treatment precluded any delay in hospitalization pending efforts to change his mother's attitudes.

Because this mother gave consent to the research without providing any safeguard for the child's psychological development, the pediatric investigator, social worker, nurse, and pediatric child development specialist collaborated in instituting a therapeutic regimen to meet the infant's developmental needs. This regimen consisted of: (1) encouraging the mother to be warmly attentive to her child during her visits and to give clear signals to him when she was about to leave; (2) assigning the same nurses to the child on each shift; and (3) providing the child with tactile, visual, verbal, and social stimulation through the provision of toys and caressing, massaging, and other forms of attention from staff members and other patients. David was also regularly moved from the metabolic mattress onto a potty in a carriage, thus allowing him more motor activity and changing his environment from a depressing, monotonous one to a more interesting one. David made appropriate developmental gains in the 2 months he was in the hospital.

Interruption of research

In some instances, a child's responses to the stress of the research may require the studies to be terminated before completion, as it was in the following case.

Charles, a blind 7-year-old boy, was expected to die within the year from an inoperable brain tumor. Charles' mother gave consent for the boy to be hospitalized and subjected to endocrine studies that could not benefit him in any way. The justification for the studies was the possibility of their leading to earlier identification of brain tumors in other children.

The mother's motives in giving her consent for the studies were complex. She told the staff that she felt Charles' life would have been worthwhile if, through the studies, it led to knowledge that would benefit other children. This statement implied that her consent was partly a way of dealing with Charles' impending death (although Charles would die, the knowledge gained through him would live on) and partly a way of compensating for his loss (Charles would die so that other children might live). However, the statement also implied the existence of unconscious anger toward Charles, since it disregarded the severe stress to which the child would be subjected.

The psychological stress proved to be particularly severe since the medical procedure heightened the

fears commonly experienced by a child at Charles' developmental stage—concern about body intactness and manipulation. Frequent venipunctures, necessary for the research, led to acute panic states in the child. Moreover, the usual means of dealing with such stress through play, visual, auditory, and tactile experiences, and motor activity were denied to Charles by his blindness and the imposed restraint necessary to the procedures.

When Charles was threatened with further restraint because reaching his difficult veins satisfactorily would require cutting through his skin, the investigator terminated the research.

In this case, recognition of the incomplete resolution of the mother's feelings about her child's impending death, developmental anxieties in the child, and the acute stress imposed by the procedures led the pediatric investigator to decide to discontinue research that could have no direct benefit to the child.

Recommendations

In view of the difficulties involved in determining the meaning of informed consent, we suggest the following safeguards for children being considered for participation in medical research:

1. The nature of the research design and all risks to the child should be assessed by a review committee that includes pediatric investigators who are not involved in the research as well as the pediatric investigator who is to conduct the study. This will provide safeguards against the investigator's inevitable bias and gaps in knowledge.

2. The review committee should include a professional person especially equipped to assess the psychological risks to the child. This person would have to be aware of those areas of development especially vulnerable to impairment at the child's developmental stage, have the interviewing skill required for assessing the child's degree of vulnerability, and understand the kinds of stress likely to be provoked by the research procedures.

3. The investigator should have a series of personal interviews with the parents and at times with the child to build a relationship of trust, and establish an understanding of the research goals and methods and of the risks involved.

4. When the investigator lacks the skill or experi-

ence necessary for preparing the parents and the child for the research, correcting their misconceptions about it, and dealing with the child's reactions as the admission date approaches, a social worker and a psychiatrist may be called upon to help fulfill these functions, in supplementary preadmission interviews.

5. The investigator, research director, nurse, social worker, and psychiatrist should plan in advance for the child's care in the hospital since special arrangements may be required to prevent impaired development.

6. The research team should include a pediatrician, nurse, child psychiatrist, child psychologist, or social worker to provide a continuing evaluation of the psychological reactions of the child and his parents to the research procedures and to train research personnel in the early recognition of emotional stress and ways of dealing with it.

7. The activities of all the staff members on the research team should be coordinated in regularly held interdisciplinary conferences.

8. Followup care should be provided to deal with whatever reactions to the research procedures may occur after the child's discharge from the hospital.

9. Parents and staff members should have an understanding of what parts of the psychological information revealed during the research are to be shared with other members of the staff and what parts will remain in confidence; and all staff members should understand the need for discretion in divulging such information.

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INVOLVING PARENTS

in THEIR CHILDREN'S DAY-CARE EXPERIENCES

MARGERY M. LARRABEE

● We hear a great deal today about "parent involvement" in programs for children.

Nowhere, perhaps, is it more important to encourage such involvement than in programs providing day care for young children, whether this care is provided in day-care centers or in family day-care homes.

The role of a day-care program is to supplement the parent's role and not to substitute for it. The preschool child needs especially to be aware of himself as a part of a family group, for it is within the family that he begins to build a sense of his own identity. His parents remain a primary source of guidance and protection and primary models for behavior. Because a day-care program necessarily includes a number of important parental responsibilities, the parents need to understand what the child's day-care experience is so that they can build on it, help the child work out his problems, and enjoy his progress.

Day-care personnel—that is, the staff members of day-care centers or the day-care mothers in family day-care homes—need to know the child's parents

and relate what they do with the child to what the parents do so that the child's developmental needs can be satisfactorily met.

The child in day care lives in two different worlds. What happens to him in his day-care placement affects what he does at home. What happens to him at home affects what he does in the day-care setting. When there is cooperation and good feeling between the mother and the day-care personnel, the child can sense a continuity in caring and a greater consistency and stability in his daily experience.

Source of observations

The successes and failures of one agency—the New Castle County Office of the Delaware Department of Public Welfare—in involving parents in their children's day-care experiences may be helpful to other day-care sources that wish to promote greater parent participation. Through its Division of Child Welfare, the department has since 1964 been placing children in licensed nonprofit day-care centers, licensed proprietary day-care centers, and agency family day-care homes. Previously, the department's only day-care activities were in licensing and relicensing day-care facilities and providing information and counseling regarding day care to families and organizations.

After the 1962 amendments to the Social Security Act made Federal funds available for developing day-care services, the welfare department expanded its day-care service in three ways:

1. Establishment of a continuing service to families who needed day care for the children. This service included: (a) preplacement counseling provided by a day-care social worker; (b) placement of children in day care, according to a signed agreement between the agency and the responsible caretaker of the child; (c) assumption by the parent or guardian, through a written agreement, of whatever portion of the day-care fee he could afford according to a standardized budget guide; and (d) further contacts as needed between the mother or other responsible person and the department's day-care social worker, with at least one interview required every 3 or 4 months. (None of the day-care facilities in the community had social workers on their staffs.)

2. Development of family day-care homes. The use

of these homes was limited to families involved in the continuing day-care service.

3. Purchase of day care in any licensed day-care center. The department had no center of its own.

From the start of this service in 1964, the agency had a broad intake policy designed to serve families in all segments of the community. The program had no economic or social means test. Willingness on the part of the child's mother, father, or other caretaker to have continuing contacts with the day-care social worker was required.

In the beginning of the program, the department received only a few applications for day-care service; most of these families were not receiving any other services from the department. Their interest had been stimulated by department contacts with a few churches and day-care centers. However, after a referral system was worked out between the department's public assistance and child welfare divisions, the applications for day care increased. By the fall of 1967, referrals from public assistance and direct applications from people not otherwise known to the department were about equal. There were also some referrals for day care from the child welfare division and from other social agencies. Eventually applications grew beyond the number that could be satisfactorily handled by the limited staff funds and day-care spaces available. The department did not change the broad intake policy of its continuing day-care service, but in practice it tried whenever appropriate to refer families to other day-care resources that would meet their needs, providing counseling and information to the families so referred. The department preferred to reserve its day-care placements for children receiving other department services or for children needing day care because of special economic, social, or psychological needs in their families.

Parent involvement

The observations are based on the first 3 years of the day-care service.

In those years many parents who came for day-care service needed help with the entire day-care fee. Others were able to pay part of the fee and did so. A few paid the entire fee themselves but sought the department's help in planning for the day-care placement and in dealing with family problems in child care and parent-child relationships.

Parents who were not interested in having continuing contacts with the agency were not helped in

meeting the day-care fee, but they were given information and counseling regarding day care.

The department provided day-care service for families in a wide range of circumstances: where the mother or father was the sole wage earner; where the mother was working out of real economic need to supplement the family income; where the mother chose to be out of the home to meet her own personal needs; where the mother sought relief from child care to devote more time to another family member, such as a sick child or her own mother or father; where the child was not getting the kind of stimulation required for optimum development.

In a number of situations the day-care service had a therapeutic purpose and effect—where the family atmosphere was charged with emotional problems; where poor family relationships interfered with child-rearing functions; where a child with a mental, physical, or emotional handicap needed experience that the parents could not provide at home; where the child was subject to abuse or neglect. In some of these situations, the day-care placement became a bridge for moving a child into or out of a foster home.

Problem areas

Out of the department's experience in providing this day-care service, various kinds of problems that parents face in placing their children in day care can be identified—problems that underscore the importance of involving parents in their children's day-care experience. These include:

1. Psychological and emotional problems arising for the mother because of placing her child in day care: a sense of loss or guilt; a sense of inadequacy as a mother; a feeling of rivalry with the child's day-care supervisor.

How the mother feels about the day-care placement can affect the child's adjustment. For example, one mother in a well-functioning home became so jealous of her child's teacher in a day-care center that the child stopped talking about what went on in the center and became extremely reluctant to attend. The social worker helped the mother understand the difference between the teacher's and the mother's roles and see the importance of allowing her child to enjoy and profit from her experience in the center.

2. Difficulties with the child at home arising from differences between the living standards in the home and in the day-care center.

An overburdened mother may resent a child's demanding things requiring changes in her home management patterns—such as cleaner clothes, good hot meals, regular times for washing hands and brushing teeth. In such instances, the social worker helped the mother understand the effect of these differences on the child and how to deal with them without undermining her own self-respect. In some instances, a resentful mother was eventually stimulated to improve her home management standards.

3. Differences between the expectations of the parents and the day-care personnel in regard to the child resulting in changes in the child's behavior unacceptable to his parents.

For example, an inhibited child who had little speech, poor mobility, and a bland expression on admission to day care blossomed out under the center's stimulation, becoming much more active and talkative and occasionally getting into mischief. Only after several interviews with the social worker, focused on the mother's smothering possessiveness in regard to her child, did the mother decide not to remove the child from the center.

Sometimes the differences are reversed, as when the family sets no limitations on the child's behavior and the day-care center institutes some controls. In such instances, a different set of problems ensue.

4. An emotional estrangement of the mother and child from each other, created or aggravated by the mother's becoming cut off from the child's daily experiences.

For example, the two young children of a socially active, working mother, who treated them well but in a preoccupied way. The children adjusted by a kind of withdrawal from their mother to the emotional sterility of a home life in which there was little interpersonal communication. Because the children did well in the center and caused no problems at home, this mother could see little need of the social worker's efforts to encourage her to take greater interest in the children's experiences in day care.

Such situations are not uncommon in one-parent families where the remaining parent goes out to work; they call for efforts to help parents build a psychological bridge between their children's life in day care and at home.

5. Unmet needs of the mother herself, which interfere with her ability to give the child the loving attention he needs at home.

The mother may have a psychological need for a



Fathers, as well as mothers, sometimes get involved in children's day-care experiences as in this Head Start project.

sense of her own worth, of belonging to society, or of direction. The mother may have a practical need for an opportunity for recreation, employment, or the development of work skills. In such instances, helping the mother first meet her own needs often resulted in improving her ability to care for her child.

For example, the social worker helped a mother of six schoolage and three preschool children meet some needs that were contributing to the sense of hopelessness that was impairing her child care ability. After two of the youngest children were placed in day care and the mother was given a chance to test out some job training and to have some social experiences, she developed better attitudes toward her children, asked questions about how to handle them, began to mobilize her own resources, and to put her major effort into homemaking.

Many other mothers with similar needs responded

positively to a personal interest in them as people, but unfortunately the mother's readiness to improve her family situation was sometimes undermined by the inadequacy of community resources, such as decent housing or appropriate employment or social opportunities.

6. A negative behavioral response to day care on the part of the child, stemming from psychological or practical problems in the home.

For example, a pampered child of an overprotective mother roved about restlessly in the day-care center, bullying other children; another child, ill-prepared by his mother for the day-care experience and left too long in the center each day, acted flighty and ill at ease. In such instances, the social worker helped the mothers see the origin of their children's adjustment difficulties and ways of easing the child's transition between home and day-care facility.

7. Fathers' difficulties in assuming their rightful role as parents.

In many families applying for day care, the father had either absented himself from the home altogether or avoided any active participation in family life, often with detrimental effects on a child's development. For example, a little girl whose father had left home spoke only with great difficulty at the time she entered day care. Psychological help secured for her was of no avail until the father returned home and took an active part in the family life.

Because the importance of the father to the child's development is so often overlooked, the day-care social worker tried whenever possible to involve the fathers in the day-care planning as a way of promoting greater participation on their part in the children's daily lives.

Roads to involvement

How can parents best become involved in their child's day-care experience? For different parents the answers are different. What leads to involvement for one parent may not for another, depending on the parent's interest, experience, personality, degree of readiness, and the presence or absence of deterrents.

The continuing day-care service in the New Castle County welfare department tried to engage the parents in the child's day-care experience from the time of application. Before any decision on placement was made, the day-care social worker discussed the nature of the service with the applicant, the possible effects of a day-care placement on the child and the family,

the fee policy, and the expectations of day-care social workers having continuing contacts with the family.

Thus, the mother (or sometimes, the father) was involved in the planning and decisionmaking from the start. When a placement was decided on, the social worker arranged for the mother and child to visit the day-care facility together and apprised the mother of the importance of preparing the child for the separation and for the experiences he would encounter in the day-care center.

Such an intake process can be an important first step in encouraging parents to take a continuing interest in their child's day-care experience. The members of the day-care center staff or the day-care mother can increase the parents' involvement by reaching out to let them know the nature of the program and its expectations of the child and by the showing an interest in the parents as individuals. This, of course happens most naturally when the mother herself or the father, takes the child to and from the day-care facility every day. Through such daily visits the mother catches the atmosphere of the program and what is happening to her child and the child becomes aware of the connection between his life in day care and at home. When day-care staff members or family day-care mothers make something special out of greeting the mother each morning and afternoon, the mother's relationship to the day-care program is strengthened. Unfortunately, the opportunity to use such informal contacts consciously to help parents become closer to their children's day-care experience is often overlooked.

When mothers have been assured of their acceptance by the warmth and openness of the day-care personnel, they usually respond to opportunities to observe their children or participate in the day-care program. Some mothers may be interested in working as part-time or full-time day-care volunteers or as full-time paid aides. Others may simply wish to observe their children as they engage in the program. Some may go on field trips with the children or take part in other special events such as a Christmas party.

Parents can, of course, also become more closely involved in their children's day-care experience through regular individual conferences with the teachers or family day-care mothers, through organized meetings for all the parents of children in day care, and through mothers' discussion or activity groups.

All these experiences can help keep the mother close to the child who is away from home all day.

improve her skill in child care, and increase her sense of acceptance and worth. Working parents can be provided opportunities for such experiences through appointments for visits on their days off from work or through special arrangements made with their employers.

Day-care personnel can also learn from parents. Parents can show them ways of bringing the children's day-care experiences closer to home by using features from the families' specific cultural or social backgrounds—songs, stories, food prepared in special ways. Mothers who are skilled in sewing can show other mothers how to make or fix their children's clothes. Parents can also be helpful to the day-care program by effectively reaching parents whom the day-care personnel have been unsuccessful in reaching.

Getting parents involved in the day-care program requires an awareness on the part of the staff of the deterrents to involvement and how they may affect particular parents. Such deterrents include:

- Social deprivation and inexperience.
- Lack of any felt need to be involved.
- Fear of involvement.
- Preoccupation with family or work responsibilities or both.
- Fear of being expected to change, to go to work, or to give up the children altogether.
- An inability to participate because of an overwhelming sense of inadequacy or hopelessness.
- A reluctance to take on any more responsibility.

Many mothers, of course, are affected by none of these deterrents and are eager to participate in the day-care program. Others are very difficult to interest. But in either case, the staff needs to recognize the mother's interest or problem and draw her in by being available to her and by offering her the kind of experiences that will have meaning for her. Often the mother herself will provide the key as to what method will work.

The social worker's role

A social worker can play a major role in keeping parents involved in the child's day-care experience. He can begin this effort with the intake process that has been described. He can continue this effort by passing on to the parents information about the



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child's behavior and progress gained from his own observation of the child and from his discussions with the day-care teachers. He can help the parent understand and use this information to keep in close communication with his child. He can help the day-care staff members, including family day-care mothers, understand the child and parents more fully so that the program can meet the child's needs.

In the continuing day-care service of the New Castle County Department of Public Welfare, social work was viewed not only as a therapeutic and problem-solving process but also as a means of helping families sustain healthy life patterns and make the best use of the day-care experience. The social worker's help was especially sought by parents in the following areas: (1) preparing for the day-care experience; (2) understanding the child's developmental needs and how to cope with specific behavior patterns; (3) learning about the child's day-care experience and how to build on it in the home; (4) understanding their own roles as parents; and (5) finding support in fulfilling their own personal needs.

In interviewing parents, the day-care social worker generally kept attention focused on the child and his use of the day-care program, but family problems that were interfering with the child's progress also were considered. Sometimes the day-care social worker worked with the parents directly on such problems, but if a social worker from another service or agency was already involved with the family, the two social workers held a conference to plan how to help the family. In some instances, such social work efforts played a critical part in keeping a floundering family together.

The day-care social worker used both casework and group work methods. She always saw the parents individually at intake and in subsequent interviews when something was impeding the child's progress in day care or the parents' involvement in

the day-care program. These interviews were sometimes held in the social worker's office, sometimes in the day-care center, and sometimes in the family's home, depending on the need of the parents and the kind of support they required.

The group work method was used primarily for continuing contacts with parents, but also at intake. The social worker conducted small meetings in which the parents discussed the children's developmental progress and ways of meeting child-rearing problems. In a few instances, the social worker also participated in parents' meetings conducted by the day-care teachers.

In both the individual and group interviews with the parents, the social worker encouraged the parents to take some responsibility for maintaining good day-care standards. When they showed concern about the quality of health inspection, the adequacy of the supervision afforded the children in the early morning hours, or the way a teacher was treating a child, the social worker helped them find ways of taking constructive action to correct substandard conditions. In some instances, a mother's experience in working for improvements in the day-care program led to a continuing interest in community action.

The social worker through the licensing process also encouraged the day-care center staff to respond creatively to the interest and demands of parents.

Some problems

A major problem in Newcastle County's continuing day-care service was the lack of consistent cooperation between the day-care social worker and the staff of the day-care centers—a problem that impeded the efforts to get parents involved in the program. This lack stemmed largely from the facts that the social worker was not an integral part of day-care operations—being on the staff of the welfare department rather than of a day-care center—and that her services were tied to the provision of financial assistance for day care. Following are some examples of the obstacles the social worker faced:

1. A tendency of day-care personnel and parents to carry over to the social worker a general feeling of mistrust of all public welfare workers.
2. Differences in points of view on parental responsibility between the social worker and the day-

care personnel. On the one hand, there was the center director who believed that all mothers receiving public assistance should go to work, while the social worker was encouraging every mother who applied for day care to consider all alternatives; on the other hand, there were day-care staff members who put pressure on parents "to get the most money from the welfare," while the social worker was trying to help the same parents contribute to the day-care fee according to the established sliding scale.

3. Pressure exerted by some centers on the welfare department to fill vacancies with children of public assistance recipients (for whom the department would pay the full fee) regardless of how far the children lived from the center and regardless of the day-care needs of children in the center's immediate neighborhood.

4. Confusion about the social worker's role, resulting in the day-care teachers sometimes assuming the social worker's responsibilities and sometimes expecting the social worker to provide more service than was possible.

5. A communication lag between the social worker and the day-care teachers and between the social worker and the parents.

Though much was accomplished, these difficulties could not be completely overcome because of the social worker's remoteness from the day-care setting. The social worker could not achieve in the minds of parents and day-care personnel the same kind of connection with the day-care program as does a social worker who is a staff member of a day-care center. When a social worker is trying to serve several day-care centers that can not afford a social worker of their own, he might achieve a closer relationship with both clients and staff if he were employed directly by the agencies in a cooperative arrangement or if he were on loan from another agency to the centers as a shared full-time staff member.

A close association with a day-care program can expedite a social worker's efforts to involve parents in their children's day-care experience. Such efforts are crucial for the child. For unless the child finds a connection between his experiences at home and away from home, he may gain little of lasting value from the day-care program and the quality of his relationship to his parents may be diluted.

FAMILIES of

CHILDREN IN FOSTER CARE

SHIRLEY JENKINS • ELAINE NORMAN

● In many inner-city areas in urban centers throughout the country, large numbers of children continue to enter foster placement each year with accompanying disruption of continuity of family patterns of child rearing. The continuing need for an extensive child welfare system of substitute care indicates not only individual failure of parents to carry out their roles, but also the increasing social and economic pressures experienced by a population living at a marginal level. The research reported in this article is part of a study of 624 children under the age of 13, who entered foster care for the first time in New York City in 1966. As such, it has implications for any large metropolitan area with comparable social indicators of poverty, mental illness, sizeable minority populations, and insufficient community-based services.

The data gathered by the research staff are derived from the family study of the Child Welfare Research Program at the Columbia University School of Social Work. The overall program encompasses a longitudinal study of the parents of placed children, the children themselves, and the activities of the placement agencies that have cared for them. The research is primarily supported by a Federal grant from the Children's Bureau.

The findings reported here are based on interviews with 390 parents of children in the study sample. Field interviews were conducted by trained social workers who made home visits and spent an average of 2 hours with each person interviewed. The respondents included 297 mothers of the placed children, 137 fathers, and 44 other persons, chiefly grandparents. In 88 cases both the mother and the father of the child were interviewed.

The data presented here are the results of the first

round of a series of three field visits. The second round has been completed and is now being analyzed. The third and final interview will be undertaken at the end of the 5-year study period. The first interview collected baseline data in the following areas: circumstances surrounding placement; feelings of the parent on the day of placement, or "filial deprivation"; attitudes toward agencies; basic social orientation; child-rearing attitudes; preferred child traits; socioeconomic circumstances; and basic demographic characteristics.

Characteristics of parents

The findings show that ethnic groups and religion tend to be important differentiating variables that are related both to the families' socioeconomic status and their reasons for placing their children in foster care. Among the mothers interviewed, white mothers made up 27 percent of respondents; Negro mothers, 42 percent; and Puerto Rican mothers, 31 percent. Mothers and fathers were designated as Puerto Rican if Puerto Rico was their birthplace. This was done because of the importance of the Spanish culture and language in their family life. The Puerto Rican group, an ethnic rather than a racially differentiated population, includes Caucasians as well as Negroes. In regard to religious affiliation, 57 percent of the mothers interviewed were Catholic; 36 percent were Protestant; and 7 percent were Jewish.

Although the interviewers tried to see the mother of almost every child in the sample, except those who had surrendered the child for adoption or were inaccessible, they did not try to see every father. This was partly because in many cases the father, or his whereabouts, was unknown and partly in deference to ma-

ternal requests not to interview fathers who might react with consequences detrimental to the mother or child. Because so many fathers were not interviewed, the ethnic and religious distribution of the 137 fathers who were interviewed was slightly different from that of the mothers and included a somewhat higher percentage of Caucasians and lower percentages of Negroes and of Protestants.

Only 13 percent of all families in the study consisted of a mother, a father, and a child or children who all lived together before the child or children's placement in foster care. Fathers had been absent from two-thirds of the families for all or the greater part of the children's lives. Thirty-six percent of the mothers interviewed were single and had never married; another 36 percent were married but were not living with their spouses; and an additional 7 percent were divorced. Many of the mothers seemed to be repeating the family situations of their own childhood. While slightly over half the mothers (53 percent) had been raised by both of their own parents, 23 percent had been brought up by their mothers only, without a father in the home; 17 percent had been brought up by a person or persons other than their natural parents; 3 percent had been brought up by their fathers only; and 3 percent had been brought up in foster care. Information on the childhood of the remaining 1 percent was not obtained.

New York was the birthplace of 37 percent of the men and 37 percent of the women interviewed; and Puerto Rico, of 30 percent of each group. Twenty-four percent of interviewed mothers had been born in Southern States, but this was the case for only 17 percent of interviewed fathers. Mothers as a group were younger than fathers. About half of the women, but only a fourth of the men, were under 30 years of age at the time of the first interview.

Socioeconomic conditions

Just before being placed in foster care, the majority of the children in the study were living in impoverished households located within the poorest neighborhoods of New York City. More than half the households in which the children were living before placement were located in the city's 14 neighborhoods having the highest juvenile delinquency rates and the lowest median family income. Many of the children were living in buildings containing health and safety hazards; among such hazards were rats, roaches, rotting floors, garbaged-littered halls, and inadequate light, ventilation, heat, or hot water.

Shirley Jenkins, left, and Elaine Norman are director and research associate, respectively, of the family study of the child welfare research program at the Columbia University School of Social Work, from which the data reported in their article were obtained. They are co-authors of a forthcoming book that is based on the full longitudinal research study.



More than half the families (52 percent) in which the children were living before placement were receiving some public assistance; and in about 45 percent, public assistance was the chief means of support. Wages or salaries were the primary means of support in 43 percent of the families; and income from sources other than salaries or public assistance, such as social security benefits or other insurance payments, alimony, or help from friends or relatives, in 8 percent. Among these families with earned income or insurance benefits, 7 percent were receiving supplementary public assistance payments.

Most of the families that were supported chiefly by public assistance had been receiving such assistance for many years, indicating patterns of chronic dependency. Forty percent had been receiving such help for 6 years or more; 11 percent for less than 1 year.

Among the families with wages or salaries, the weekly income was in most cases below the citywide average. Only 28 percent had total incomes of \$100 a week or more. The median income of the salaried families fell between \$75 and \$99 a week, and in some cases the income reached this level only because supplementary public assistance was being received.

The research team developed a socioeconomic scale relevant to this impoverished group. The scale included five classifications: source of support graded by amount of income if salaried, or duration of public assistance if relevant; educational attainment of the best educated adult in the household; number of negative housing conditions; and rank of neighborhood among all city neighborhoods based on census data for income and juvenile delinquency. Within the sample, socioeconomic scores derived from this scale were assigned to each family, who were then grouped into high, middle, or low socioeconomic categories, according to their place on the scale. Thus, the terms "high" or "middle" socio-

economic status, as used in this report, refer only to the family's position relative to other families within the study group, and not in relation to any other population.

Reason for placement

The single common denominator among all families in the study was that they had children in foster care. The reason for the children's placement away from home assumed major importance in the data analysis. Although reasons were noted on the case records at intake, the research staff undertook to delve deeper for the underlying reasons for placement, using the designation noted at intake, information in the case record after further investigation was made, the family interview, respondents' statements, and the judgments of social workers.

Although in nearly all cases the families had many unsettling problems, the factor that appeared to be most critical in the decision to place the child was recorded in the study data as the reason for placement. The reliability of these designations was tested by studying agreement among independent judges on the research staff. The findings showed the following reasons for placement:

- Mental illness of the child-caring person, determined either by professional diagnosis or the person's hospitalization, in 22 percent of the cases.
- Child behavior or personality problems, in 16 percent.
- Severe parental neglect or abuse of the child, 14 percent.
- Physical illness of the child-caring person, 11 percent.
- Unwillingness or inability to continue child care, 11 percent.
- Unwillingness or inability to assume child care, 10 percent.
- Abandonment or desertion, 8 percent.
- Other types of family dysfunction, 9 percent.
- Other reasons, 1 percent.

Differences in reason for placement were associated with the families' ethnic or religious backgrounds. White Jewish children, for example, were placed in foster care most often because of their own behavior; white Christian children (Protestant or

Catholic) and Puerto Rican children (primarily Catholic) were placed most often because of the mental or physical illness of the child-caring person. A greater proportion of Negro children than of white or Puerto Rican children were placed in foster care because of parental neglect and abuse. These generalizations, however, do not apply to all cases; each ethnic and religious group included some children who were placed for nearly every reason listed.

Socioeconomic factors were also related to the child's entry into foster care. Children placed because of their behavior tended to come from families of higher socioeconomic levels. Children placed because of physical illness in the family tended to come from families of the middle or lower socioeconomic levels. Children placed because of neglect or abuse tended to come from families on the lowest socioeconomic level. Mental illness as a reason for placement, however, was evenly distributed among high, middle, and low socioeconomic groups.

In cases in which the main reason for placement was child behavior or mental or physical illness of the child-caring person, mothers tended to consider the placement of the child as having been "absolutely necessary." Where the reason for placement was neglect or abuse, abandonment or desertion, or family dysfunction, the mothers tended to see the placement as "not at all necessary." Where a medical agency or the school had first suggested the idea of placement, the mothers tended to see it as "absolutely necessary." When a complainer, the police, or the courts had initiated the action leading to placement, the mothers tended to see it as "not at all necessary."

Filial deprivation

A major area of investigation in the study has been how parents felt the day their child was placed, one aspect of filial deprivation. A background discussion of this area of investigation has already been published in *CHILDREN*,¹ and some of the recent findings are being presented in another publication.² Therefore, only some highlights of the findings in this regard will be given here.

The parents were asked about 12 types of feeling: sadness; anger; bitterness; relief; thankfulness; worry; nervousness; guilt; paralysis; shame; emptiness; and numbness. Individual respondents reported having experienced from none to all 12 types of feeling on the day of placement. The mothers and fathers reported experiencing each of these types of feeling: sadness (87 percent of the mothers and 90

percent of the fathers); worry (76 percent and 68 percent); nervousness (68 percent and 56 percent); emptiness (60 percent and 42 percent); anger (45 percent and 50 percent); bitterness (43 percent and 43 percent); thankfulness (42 percent and 57 percent); relief (40 percent and 42 percent); guilt (39 percent and 30 percent); shame (36 percent and 39 percent); numbness (19 percent and 14 percent); paralysis (16 percent and 11 percent).

A significantly greater proportion of mothers of relatively higher socioeconomic circumstances reported being thankful and relieved upon placement than of mothers in the other socioeconomic groups. On the other hand, proportionately more mothers of relatively low socioeconomic circumstances reported being nervous and worried. The more mothers viewed placement as necessary, the more likely they were to have felt thankful and relieved on the day of placement and the less likely they were to have felt empty and worried. On the other hand, significantly more mothers who viewed the placement as not at all necessary felt angry, ashamed, and bitter.

The parents' feelings were significantly related to several reasons for placement. Thankfulness was significantly higher and guilt and anger lower among families whose children had been placed because of physical illness of the mother. In families whose children had been placed because of behavior problems both guilt and relief were significantly higher and anger and bitterness significantly lower. Anger was significantly more frequent among mothers whose children had entered foster care because of severe parental neglect or abuse, or family dysfunction.

Parental attitudes

In addition to inquiring into the parents' feelings at a time of intense crisis, the study looked into the parents' general social orientation and their attitudes toward child-caring agencies and child-rearing methods and goals.

Social orientation. The parents' attitudes toward life in general were studied to gain an understanding of the family's social orientation. The interview instrument included 15 items intended to identify attitudes of alienation, trust, and calculation. The items used for studying alienation were developed by Srole;³ those used in relation to trust and calculation were developed by Struening and Richardson.⁴

Preliminary inspection of the responses indicates that, on the whole, the parents of children placed in foster care see the world primarily from a calcula-

lating and alienated point of view. Of all items, the one with which the greatest number of respondents (89 percent of the mothers and 96 percent of the fathers) agreed was: "A man should be allowed to make as much money as he can." The item achieving the next highest level of agreement (85 percent of the mothers and 88 percent of the fathers) was: "In a society where almost everyone is out for himself people soon come to distrust each other." Conversely the item with the lowest level of agreement was "Most people can be trusted."

On the basis of the Srole anomie scale,³ Puerto Rican mothers and fathers of children in the sample were found to be significantly more alienated than either the white or the Negro parents. With regard to feelings, significantly more mothers who had an alienated social orientation felt anger at the time of the placement. On the other hand, significantly more mothers whose social orientation was generally trusting had felt shame.

Attitudes toward agencies. The interview instrument also included items relevant to the attitudes of parents toward child-care agencies. These items were used to identify three mutually exclusive types of perception of child-caring agencies: as facilitators, as usurpers, and as surrogates. The great majority of the mothers and fathers saw agencies as facilitators of care, agreeing with the statement: "It's a good thing that there are institutions and foster mothers to do the job when a real mother is not able to take care of her child." However, about 15 percent of the parents saw the agencies as usurpers, agreeing with the statement: "Agencies act like parents have no rights at all—they think they own the children." A few parents—7 percent—saw agencies as surrogates acting *in locus parentis*.

Those mothers and fathers who were at the low socioeconomic levels were more likely to view child-care agencies as usurpers or surrogates. Protestant and Negro parents were the most likely of all groups to view agencies as usurpers, whereas Puerto Rican parents were the most likely to see agencies as parent surrogates. Parents whose children had been removed from their homes because of neglect or abuse were more likely to regard the child-care agency as usurper of parental rights. Mothers who saw agencies as usurpers were more likely to feel angry and ashamed on the day of placement.

Child-rearing attitudes. With the hypothesis that attitudes would be related to family characteristics,

the investigation gathered data on parental attitudes in child rearing, especially in relation to the permissive-authoritarian spectrum. The interviewers used six sets of paired items developed by Loevinger,⁵ each representing socially acceptable parental behavior. The findings showed that two-thirds of the parents of the children in the sample had strongly authoritarian attitudes in response to such behavior as hitting, crying, lying, and talking back. Parents of higher socioeconomic levels tended to be more permissive, as did white Jewish mothers and fathers. Authoritarian attitudes predominated among Protestant Negro parents but not among Catholic Negro parents.

Preferred child traits. The parents were also asked what traits they considered to be most important for a 10-year-old child to have. Each respondent was asked to choose three traits from seven included on a checklist developed by Kohn.⁶ The traits most frequently chosen by both mothers and fathers were "honest," "obedient," and "neat and clean." The traits least frequently chosen were "self-controlled," "considerate," and "dependable."

A larger proportion of parents at the higher socioeconomic level chose "happy," "considerate," and "self-controlled" than at the other socioeconomic levels. Parents at the middle socioeconomic level most often chose "honest," "dependable," and "obedient." Mothers and fathers at the low socioeconomic level chose "neat and clean" as a desirable child trait with far greater frequency than parents at the middle or high levels.

Investment and aspirations

Several open-ended sentences were included in the interview to explore the emotional investment in the child on the part of each parent. Both mothers and fathers were asked to complete seven incomplete sentences, such as: "For a mother a child is . . ." and "For a father a child is . . ." An analysis of their spontaneous responses could be classified into five categories, which described children as a burden; as a source of happiness; as a value—"a source of pride"; as an investment—"a reason to exist"; and as a relationship—"love."

About one-third of the mothers and the fathers saw the child as an "investment," and one-fourth

saw the child as a "value." Mothers and fathers tended to misjudge and negate each other's feeling for a child. Thus, although only 5 percent of the mothers regarded the child as a burden to themselves, 10 percent of the fathers said a child was a burden to a mother. Similarly, while only 9 percent of the fathers regarded a child as a burden to themselves, 17 percent of the mothers saw a child as a burden to a father. Mothers found it more difficult to empathize with fathers than fathers with mothers. Only 4 percent of the fathers said they could not complete the sentence, "For a mother a child is . . .," but 21 percent of the mothers could not complete the comparable sentence, "For a father a child is"

To assess aspirations, each parent was asked, "If you had three wishes, what would they be?" Although interviewed separately—and more often than not, living apart—mothers and fathers expressed wishes that closely corresponded. The wishes mentioned by approximately half of the mothers and half of the fathers were, "to have my child back," and "to have a home with my family all living together." Other wishes frequently mentioned were for mental or physical health, to have or to find a good spouse, to get a good job, to earn money, to get "off welfare," to find happiness.

For parents to wish for a satisfying family life and for financial security might be expected. For most parents such wishes might even be interpreted as oriented to reality. However, a review of the study findings, including the data on family breakdown, illness, and impoverishment, may lead to a different interpretation here. What may be a reality-based wish for some parents may be only an expression of fantasy for families with children in foster care.

¹ Jenkins, S.: Filial deprivation in parents of children in foster care. *Children*, January–February 1967.

² ———: Separation experiences of parents whose children are in foster care. *Child Welfare*, June 1969.

³ Srole, L.: Social integration and certain corollaries: an exploratory study. *American Sociological Review*, December 1956.

⁴ Struening, E. L.; Richardson, A. H.: A factor analytic exploration of the alienation, anomia and authoritarian domain. *American Sociological Review*, October 1965.

⁵ Loevinger, J.: Measuring personality patterns of women. *Genetic Psychology Monographs*, February 1962.

⁶ Kohn, M. L.: Social class and parental values. *American Journal of Sociology*, January 1959.

of dreams and reality : KIBBUTZ CHILDREN

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Family structure and child-rearing procedures in the kibbutzim, the communal settlements in Israel, have intrigued Western investigators for some time, although less than 5 percent of all Israeli children are being reared in kibbutzim. In a kibbutz, the good of the entire community and complete equality of rights and status for all who compose it are primary values. Private property does not exist. Neither does the family in its traditional sense as a setting for child rearing.

From infancy to maturity, kibbutz children are reared in children's houses with other children of their own age. The biological mother is intensively involved in caring for the infant during the first few months of life, but afterward the main responsibilities for the child's training and socialization up to the period of puberty are given to the housemother, or *metapelet*. From the start, although the child visits with his parents and biological brothers and sisters for a few hours every day and for longer periods on weekends and holidays, the main center of his life is the children's house. His peer group provides a constant social environment, presided over by the housemother who is joined by teachers and youth leaders as the child grows older.

The cardinal purpose of the founders of the kibbutzim in establishing these child-rearing procedures was to create a new personality or "new man" who could easily adjust to communal living. In his new book, "The Children of the Dream,"* Bruno Bettelheim attempts to penetrate into this personality of the "new man" and learn to

what extent the dream of the founders of the kibbutzim has been realized. By frequent comparisons between education in a kibbutz and in America, Bettelheim also tried to glean some ideas and principles that may be transferred from the kibbutz experience to the American scene.

Much of what Bettelheim has to say is consonant with the findings of systematic studies of the kibbutz published some years ago.¹⁻⁴ Among the chief "good" findings concerning the members of the second generation of the kibbutzim is an absence of delinquency and of severe psychopathology in the form of schizophrenia, an absence of inner conflict in the kibbutz personality, a devotion to community and country, an effectiveness in teamwork and interpersonal relations, and a general readiness to continue in the collective form of life. On the negative side of the ledger, Bettelheim points to a severe repression of sexuality in adolescence and an emotional distance between the kibbutz child and others—whether parents or peers—that Spiro has called introversion.¹ Bettelheim also sees the second generation of children of the kibbutzim as lacking a capacity for intimacy and exhibiting only average ability and achievement because of a "leveling impact."

Some differing opinions

The author agrees with my own earlier investigation concerning the psychodynamic and intrapsychic processes that underlie the kibbutz personality.³⁻⁶ We have both noted the low intensity of the Oedipal relationships,

the diffuseness of identification to superego formation, and the relative simplicity of the psychic defensive structure. However, Bettelheim makes some additional observations, speculations, and conclusions with which I must take issue.

1. *The leveling effect.* One of the first speculations social scientists usually make about the kibbutzim is that the child-rearing methods must produce some kind of homogenized child. Bettelheim is caught up in a similar conjecture. In support of the contention that the kibbutz educational system has this leveling effect, he cites without identifying a "nationwide study of scholastic achievement" in Israel. In this study kibbutz adolescents ranked second in achievement tests—next to students of standard Israeli urban high schools. In the kibbutz group, 30 percent scored above 75; 32 percent, from 64 to 75; and 38 percent, less than 64. But only 24 percent of the young people from a rural cooperative settlement (*moshav*) scored above 75; 23 percent, from 64 to 75; and 53 percent, less than 64. Thus, there is no question as to the superiority of the kibbutz youngsters when compared with other rural youngsters on the achievement tests. However, Bettelheim makes a further breakdown of the high-scoring groups, noting that 2.3 percent of the nonkibbutz rural group scored 85 or above, compared with 2.1 percent of the kibbutz group.

*Bettelheim, Bruno: *The Children of the Dream*. The Macmillan Company, 866 Third Ave., New York, N.Y. 10022. 1969. 363 pp. \$6.95.

He cites these figures, which are probably not significant statistically, as evidence of the "leveling effect" on kibbutz children. Moreover, he disregards the possibility that the achievement tests are geared to a more conventional curriculum than the curriculum of the kibbutz schools.

From the evidence offered, it is doubtful that "the leveling influence seems to have reduced to a respectable middle level those students who had a potential to be top performers." The varied imaginative productions reported from the kibbutz school³ hardly lend support to such a conclusion. To be sure, kibbutz education is not competitive nor achievement oriented, yet it is remarkable that it produced the second highest level among the groups studied nationally.

2. *The kibbutz product.* An attempt is made in this book to explode "the legend . . . that kibbutz-educated youngsters make the best soldiers." Bettelheim admits that soldiers from kibbutzim have a great *esprit de corps* and great readiness to make the supreme sacrifice. He does not question their courage, but he cites the high casualty rate of soldiers raised in kibbutzim and quotes an officer to support his belief that they are not flexible enough to make the complex decisions necessary to survive in war. He does not consider that the high casualty rate may be due to the fact that many kibbutz youngsters become paratroopers, pilots, or officers. Such roles of leadership and skill often demand flexibility and capability for complex decisions, which the kibbutz-reared young men have amply demonstrated.

3. *The problem of intimacy.* According to Bettelheim, the kibbutz child does not develop the capacity for intimate relationships because he does not have a close relationship with any one person. He tends to relate to many people, but in a superficial and impersonal manner. It seems to Bettelheim that "a child who has lived a life of equality receives no vast surplus of . . . dependent intimacy, and without it he cannot later afford to give it to others." Living with the group, the child "fails to live intimately with any one of them."

It may seem reasonable to assume that the kibbutz child lacks an intimate relationship with peers and adults. However, examination of some post-

humously published diaries of kibbutz adolescents and my own close observation of the interaction between some parents and children suggest the contrary. The fact is that kibbutz young men and women fall in love, get married, and develop close relationships with other men and women. There is a difference between intimacy and emotional closeness on the one hand and between demonstrativeness on the other. The kibbutz youngsters are trained to shun public demonstrations of affection, but this does not necessarily betray a lack of capacity for close relationships.

4. *Repression of sexuality.* Bettelheim contends that since sexuality of kibbutz adolescents is inhibited by the demands of kibbutz morality, especially under the heightened stimulation of mixed sleeping quarters, the "repression" generalizes to the entire personality and affects later capacities, including mature sexual love and intimacy. Moreover, he states that this repression "drains" the energies of kibbutz adolescents.

I doubt whether repression is the process; it is more likely conscious *suppression*. Evidence shows that once a kibbutz youngster enters the army, his inhibitions do not persist.^{3,5} They do not prevent him from heterosexual love, marriage, and procreation. Again, although the young person in the kibbutz is not as demonstrative as is the American college sophomore, his sexuality is not any less mature. The absence of homosexuality in the kibbutz setting is additional evidence that heterosexual drives are temporarily suppressed rather than pathologically repressed. Bettelheim's findings of "endemic fatigue" in the kibbutz adolescent are based on personal observation not readily validated.

5. *Emotional flatness.* Bettelheim reports his impression of the "emotional flatness" of the second generation in the kibbutz. He maintains that there is no "depth" in the emotions of such young people. It may be, however, that the casual observer cannot fathom the depth in his interaction with persons who on the whole tend to be shy. Bettelheim says, "[I] failed to evoke any such depth in the younger generation, though I found it often enough in the founding generation and in those who were kibbutz-born but had left." This is a rather curious comment, for it im-

plies that kibbutz-born youngsters are capable of achieving emotional depth if they leave the kibbutz but not if they remain.

Other issues

Two more issues, one of theoretical and the other of practical import, are worthy of consideration. The first concerns the structure of the psyche of the kibbutz-born person. Bettelheim regards the superego of the kibbutz child as a "collective superego." Since the child does not introject the standards of his parents because of the distance of his relationship with them, he adopts instead the collective conscience of the peer group. In this instance, the superego is close to the external reality itself—the demands of the group. Yet the conscience of the kibbutz child operates in the absence of the group, just as the conscience of the Western child controls his behavior in the absence of the parents who are responsible for its genesis.

Bettelheim calls the kibbutz youngster's conscience a simplified superego, since no internal dialogue created by the internalization of conflicting standards of parental figures takes place. One might ask whether introjection of group standards does not involve the introjection of the standards of individual members of the group. The child in the kibbutz introjects standards of parents as well as of the housemothers or meta-

A moment of music and relaxation among a group of adolescents in a kibbutz.



plot, who do not always agree on a "monolithic" kibbutz ideology. Therefore, the possibility of complexity in the kibbutz child's superego should not be ruled out. However, the notion of a "collective superego" is worthy of further detailed study.

The issue of practical import is the possibility of applying child-rearing principles of the kibbutzim in our own society. Suggestions are being made today for a reconsideration of the possibilities of child rearing in institutional settings, after a long period of widespread opposition to institutional placement of children. I have suggested that we might consider the use of well-staffed and well-directed institutions for many young children and even infants who are in overpopulated, neglected, and often disorganized family settings in slum and poverty areas. As I explained to the Wisconsin Psychiatric Association, "Multiple mothering in stimulating institutional environments may well be preferable to 'continuous' mother-child relationships when the mother is inadequate, retarded or disturbed, and a father is absent permanently or intermittently,

and where the setting is that of poverty and extreme cultural deprivation."⁶

Bettelheim agrees directly and implicitly with these ideas. However, the implementation of such programs would be a highly complex, difficult undertaking. Finding parents who would be willing to be separated from their children and finding the equivalent of good metaplot for such institutions could be major obstacles. Nevertheless, recognition of the desirability of having institutions may be an important first step to innovative planning.

A great many other practical and theoretical issues could be discussed, for the author deals with a variety of topics in a thought-provoking manner. However, the book suffers from a number of handicaps under which the author labored—the brevity of his time in Israel, a language barrier, and a tendency to draw generalizations from episodic material. Moreover, by neglecting the indigenous Israeli culture and by comparing the evolving kibbutz personality with a semblance of a Western "national character," he tended to consider some characteristics to be "uniques" to the kibbutz, when, in fact,

they may be part of the total rural society of Israel.

Despite these handicaps, Bettelheim has produced a highly stimulating and theoretically sophisticated work. "The Children of the Dream" may serve as a rich source of hypotheses for future systematic investigations into personality development in the kibbutz.

¹ Spiro, M. E.: *Children of the kibbutz*. Harvard University Press, Cambridge, Mass 1958.

² Rabin, A. I.: Kibbutz children—research findings to date. *Children*, September–October 1958.

³ ———: Growing up in the kibbutz. Springer Publishing Co., New York, N.Y. 1965.

⁴ ———: Kibbutz mothers view "collective education." *American Journal of Orthopsychiatry*, January 1964.

⁵ ———: Some sex differences in the attitudes of kibbutz adolescents. *Israel Annals of Psychiatry and Related Disciplines*, Vol. 6 No. 1, 1968.

⁶ ———: Some implications of kibbutz child rearing. Unpublished paper presented to the Wisconsin Psychiatric Association, February 1966.

British publications

THE DEVELOPMENTAL PROGRESS OF INFANTS AND YOUNG CHILDREN. Mary D. Sheridan. British Ministry of Health. Reports on Public Health and Medical Subjects No. 102. U.S. distributor: British Information Services, 845 Third Ave., New York, N.Y. 10022. 1968. 11 pp. 50 cents.

Briefly describes the normal behavior patterns of infants and young children at different ages between 1 month and 5 years—posture and large movements, vision and fine movements, hearing and speech, and social behavior and play.

SOCIAL WORK IN CHILD CARE. Elisabeth Pugh. Routledge & Regan Paul Ltd., London, England. U.S. distributor: Humanities Press, 303 Park

Ave. South, New York, N.Y. 10010. 1968. 118 pp. \$1.50.

Examines major aspects of child care services in a local public agency in the United Kingdom, including preventive work with parents and children at home, reception into care, the child in care and his family, foster care, residential care, adoption, and the children's department itself.

BLIND AND PARTIALLY SIGHTED CHILDREN. Shirley R. Fine. Department of Education and Science, London, England. U.S. distributor: British Information Services, 845 Third Ave., New York, N.Y. 10022. 1968. 43 pp. \$1.20.

Reports the findings of a survey of 2,191 children in special schools and

classes for the blind and partially sighted in England and Wales, conducted between 1962 and 1965. Include data on clinical diagnosis, etiology, visual acuity and fields, previous schooling, mobility, intelligence, additional handicaps, mannerisms, teaching methods, use of visual aids, and attitude of children, parents, and teachers.

BEGONE DULL CARE: an informal guide to residential care of children. Ben Vincent. Advisory Council on Child Care, Home Office, London, England. U.S. distributor: British Information Services, 845 Third Ave., New York, N.Y. 10022. 1968. 102 pp. \$2.50.

Advises institutional houseparents of ways of dealing with new groups of children and their parents, transfer housekeeping, visitors, school, the teenager, smoking, telling the truth, feelings of failure, television, and other aspects of the houseparent's daily routine.

HERE and THERE



Courts and AFDC

Durational residency requirements for persons seeking public assistance were declared unconstitutional by the Supreme Court of the United States on April 21, 1969. The Court, in a 6-to-3 decision, ruled that the 1-year waiting period required of persons coming into Connecticut, Pennsylvania, and the District of Columbia has the "purpose of inhibiting migration by needy persons into the State" and is, therefore, "constitutionally impermissible."

As a result of the ruling, Secretary of Health, Education, and Welfare Robert L. Finch on June 3 issued regulations that prohibit States from imposing durational residency requirements as a condition of eligibility for public assistance under public assistance titles of the Social Security Act. The regulations cover all Federal-State public assistance programs including aid to families with dependent children (AFDC).

At the time of the ruling, 39 States and the District of Columbia had durational residency requirements for applicants seeking assistance under the AFDC program. Because of pending court cases, such requirements had been suspended in seven States and the District of Columbia in some instances for more than a year before the Supreme Court ruling.

The Court reaffirmed the appellate courts' rulings that "the nature of our Federal Union and our constitutional concepts of personal liberty unite to require that all citizens be free to travel throughout the length and breadth of our land uninhibited by statutes, rules, or regulations which unreasonably burden or restrict this movement." In the decision, known as *Shapiro v. Thompson*, the Court pointed out that "the prohibition of benefits to residents of less

than a year creates a classification which constitutes an invidious discrimination denying them equal protection of the laws."

"A State may no more try to fence out those indigents who seek higher welfare benefits than it may try to fence out indigents generally," the decision stated. "... we do not perceive why a mother who is seeking to make a new life for herself and her children should be regarded as less deserving because she considers ... the level of a State's public assistance. Surely such a mother is no less deserving than a mother who moves into a particular State in order to take advantage of its better educational facilities."

Officials in the Department of Health, Education, and Welfare have estimated that the ruling could add 100,000 to 200,000 people to various programs of public assistance, at an increased cost of between \$140 million and \$200 million a year to Federal, State, and local governments. At present, the Federal Government pays about 55 percent of the cost for assistance programs.

...

Maine's regulations setting maximum family grants for recipients of aid to families with dependent children (AFDC) were declared "void and unenforceable" by a three-judge Federal District Court for the Southern Division of the District of Maine on March 21, 1969. In the case of *Westberry v. Fisher*, the court ruled that the Maine State Department of Health and Welfare discriminated against large families in violation of the equal protection clause of the 14th amendment, by limiting AFDC grants to families to \$250 and by limiting family budgets—or total income from all sources for families receiving AFDC—to \$300.

Pointing out that the State is "free

to take reasonable steps" to allocate its resources available for AFDC on a nondiscriminatory basis, the court stated: "We are aware that the impact of our decision upon the State's AFDC program, in the absence of an additional appropriation, may mean some reduction in the amounts of grants to many present recipients." It noted that seven States have regulations providing percentage reductions or similar non-discriminatory methods for limiting standards of need or grants.

The court also noted that the State's maximum grant regulation created "a class of needy children who receive a lesser amount of public assistance than do other children who are in all respects similarly situated, except that they live in smaller families."

Youth participation

At its annual meeting in New York City May 1-2, the National Assembly for Social Policy and Development, Inc., added six young people under 20 years of age and three young adults between 20 and 26 to the 300 older persons who compose its trustee membership. By this action, the Assembly fulfilled one of the 130 recommendations of a youth-adult Dialogue of Ages, which took up a full day of the annual meeting.

The "dialogue" brought together 99 young people representing a broad spectrum of backgrounds from all sections of the United States and 152 adults who are members of the National Assembly, either as individuals or representatives of organizations. Groups of 10, composed of both young people and adults, probed the following issues of mutual concern to the younger and older generations: the sharing of power, the emergence of autonomous youth organizations, collaboration of young people and adults on problems of social control, establishment of trust between generations, young people as volunteers, the world of work, educational experience for intergenerational collaboration, and emergence of new sex roles and family patterns.

Differences in values, described as a "people gap," rather than the difference in chronological age, or "generation gap," were frequently cited to explain misunderstandings between young people and adults. One of the value differences noted was in the sense of urgency

about resolving the social lags representing poverty and racial discrimination. As one teenage participant put it, "We want to do something about the problems now."

One recommendation called for establishment of local and national youth task forces to study the role of young people in bringing about social change. Among other recommendations were those urging the National Assembly and other groups to use their influence to see that—

- The voting age be lowered to 18.
- Young people be allowed to participate in decisions that affect their lives, as well as in decisions bearing on societal and environmental conditions—in such ways as being given an equal role with adults in designing and carrying out policies in regard to high school and college curriculums, faculty selection, and budgeting; and serving with adults on draft boards.
- Economic, medical, and educational support be provided to each needy family on a level and in a manner that insures human dignity.
- Minimum and maximum age requirements for jobs be eliminated and eligibility be determined by ability and qualifications.
- Free education be made available from kindergarten through college, through Federal funding of the educational system.
- Age requirements for all elective offices be lowered.
- Adults and youth work together in developing educational programs to serve the community's needs.
- National programs of adequate income maintenance be established.
- Artificial barriers between school and work be removed to provide students an opportunity to move freely from school to work and vice versa.

The recommendations will be studied during the next year by a task force that includes young people as full participants and by Assembly members at regional conferences.

New publications

The first issue of *Day Care Notes*, published by the Children's Bureau on behalf of the Federal Panel on Early Childhood, came off the press in April. Designed to bring information about new Federal programs, policy changes, and other current activities to persons

in the field of day care, *Notes* will appear from time to time on an irregular schedule. *Day Care Notes* is distributed in bulk to national, regional, State, and local governmental and voluntary agencies and organizations concerned with day care.

Sharing, a newsletter designed to present information about comprehensive service programs for schoolage pregnant girls, was launched recently by the Cyesis (Pregnancy) Programs Consortium of Yale University and the University of Pittsburgh, with support from the Children's Bureau. It carries reports of workshops for persons who work in such programs, book reviews, abstracts of articles, and reports of current programs and other items. Copies may be obtained from the editor, Marion Howard, Room 406, 715 G Street NW., Washington, D.C. 20001, as long as supplies last.

Child development

The adequacy of measures now being used to test the achievement potential of bilingual children is challenged by a study conducted at the University of California at Los Angeles by Tom Hickey, a doctoral candidate in the Division of Behavioral Sciences. The study of 320 Head Start children in Los Angeles County, Calif., indicated that the Peabody Picture Vocabulary Test (PPVT), which has been used by Project Head Start to measure verbal learning ability since 1965, presents special problems of comprehension to the bilingual child whose primary language is Spanish.

In the study Caucasian children between 3.5 and 5.6 years of age who speak only English had little trouble identifying pictures representing such verbal nouns as falling, hitting, and climbing; in contrast, bilingual Mexican-American children of the same age often were baffled by pictures of a language form that is not found in Spanish.

The investigator accepted the validity of the PPVT for measuring the verbal learning ability of young English-speaking children, including those who are handicapped, retarded, or culturally deprived. On the basis of his findings, however, he questioned the value of using the PPVT to predict scholastic achievement of Mexican-American children,

who are not members of the cultural group upon which the test was standardized.

For the study, raw scores obtained by giving the PPVT to 100 Caucasian boys and girls whose average chronological age was 4.6 years and 100 Mexican American boys and girls whose average chronological age was 4.8 years were converted to mental age equivalents. The median mental age of the Caucasian children, 3.8 years, was significantly higher than the corresponding median mental age, 3.2 years, of the slightly older Mexican-American children. This difference practically disappeared when the scores were adjusted to exclude items that involved verbal nouns (about 20 percent of the PPVT pictures). On the adjusted tests, the median mental ages rose to 4.0 years for the Caucasian children and 3.9 years for the Mexican Americans.

A second part of the study, in which no verbal nouns were used, registered identical median mental ages of 4 years for 60 Caucasian and 60 Mexican American boys and girls, although the median chronological age of 4.7 years of the Caucasians was 0.1 of a year less than that of the Mexican-Americans.

All the children in the study were from families receiving public assistance. On the basis of his findings, Mr. Hickey suggests that Mexican-American preschool children be evaluated by other instruments and methods, or—the PPVT test is used—that the programmed error be recognized and necessary interpretations made.

Child health

Children with cleft palates who cannot speak clearly although they are able to close off the nasal passages may need psychological help to improve their speech patterns, investigators conducting long-range interdisciplinary studies in cleft palate at the University of Pittsburgh School of Dentistry have suggested.

The investigators, Betty Jane McWilliams and R. H. Musgrave, M.D., working at the university's Cleft Palate Research Center under a grant from the National Institute of Dental Research, have analyzed the speech and behavioral problems of 170 children with cleft palates. The children, who were between 3 and 10 years of age, were divided into three study groups. The first

group consisted of 32 children with essentially normal speech. The second group included 77 children who were able to close off the nasal passages by elevation of the soft palate, but who made errors in articulation of consonants that could not be explained on the basis of physical limitations. The third group of 11 children spoke nasally, making errors in articulation characteristic of incomplete palatal closure.

The investigators found that children in the second group, who made errors in articulation but whose voices were not nasal, seemed to have the necessary palatal mechanisms for good speech. These children showed greater emotional disturbances, reflected in bad temper and bed wetting, than children in either of the other groups. The investigators concluded that the poor speech of children in the second group is likely to be the result of psychological, not physiological, factors.

The number of deaths due to accidental poisoning of children under 15 years of age reached a 25-year low of 345 in 1966, according to the National Center for Health Statistics, although the number of deaths from accidental poisoning in the total population increased during the same period.

Reports to the National Clearinghouse for Poison Control Centers show that in 1966 aspirin and salicylates caused 92 of the 155 deaths from drugs in young children; lead and lead compounds, 38; petroleum products, 35; corrosive aromatics, acids, and caustic alkalis, 10; and other solid and liquid substances, 72.

Estimates based on the Health Interview Survey, carried out by the National Center for Health Statistics during the 1967 fiscal year, indicate that accidental poisonings occurred among 384,000 children under 6—a rate of 16 for every 1,000 in the age group.

Accidental deaths in 1968 decreased 8 percent among children under 15 from the number in 1967, but sharply increased among older children and young people, according to figures compiled by the National Safety Council. The 8,700 accidental deaths among children from 5 through

14 years of age in 1968 represented a 12-percent increase; the 23,300 accidental deaths among young people between the ages of 15 and 24, a 9-percent increase. Part of these increases is attributable to a 2,000 rise in deaths from motor vehicle accidents among persons between the ages of 5 and 24.

Mental health

Admission rates for children under 18 years of age to both outpatient and inpatient psychiatric facilities in the United States almost doubled in the 8 years before 1967, according to the findings of a study recently completed by the National Institute of Mental Health. The study found that in 1966 about 473,300 children under 18 years received some service at a psychiatric facility. However, it concluded that, on the basis of estimates from three surveys of school children needing psychiatric care in Los Angeles, Chicago, and Georgia, about 1,400,000 children in this country were in need of such care during that year.

Of the estimated 473,300 children who received service, 84 percent were seen at outpatient psychiatric clinics; 14 percent were in public or private mental hospitals or general hospitals; 2 percent were in residential treatment centers; and less than 1 percent were in psychiatric day-care programs.

Two-thirds of the children seen at outpatient psychiatric clinics were 10 to 17 years of age, while over 50 percent of the children seen in psychiatric day-care programs were in this age group. In inpatient facilities, 10- to 17-year-olds accounted for from 76 to 95 percent of the children seen—76 percent in general hospitals, 89 percent in public mental hospitals, and 95 percent in private mental hospitals.

About 65 percent, or 300,000, of all the children who received psychiatric care were boys. In all the facilities except general hospitals, there were relatively more boys than girls with diagnoses of "personality disorder" and relatively more girls than boys with diagnoses of "psychoneurotic disorder." Brain syndromes and mental deficiency were more frequently diagnosed among children under 10 years of age than among older children. Psychotic disorders—in particular, schizophrenic reactions, psychoneurotic disorders, and

personality disorders—were more frequent among children 10 to 17 years of age.

The study also found that mental health resources for children in rural areas are few in number, although the number of mental health clinics throughout the country has increased substantially—owing in large part to Federal support under the National Mental Health Act of 1946. For example, of the 2,007 clinics open in 1965, only 234 located in rural areas served children.

It is estimated that if the child population continues to grow at its present rate, by 1975 there will be over 77½ million children under 18, of which 1½ million will need psychiatric help.

These and other data are included in the study report, "Utilization of Psychiatric Facilities by Children: Current Status, Trends, Implications," by Beatrice M. Rosen, Morton Kramer, Richard W. Redick, and Shirley G. Willner, available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. (Price: 75 cents.)

Maternity care

In the first 3 years after the inception of a maternity and infant care project at the University of Nebraska, Omaha, the number of women reporting at the hospital for delivery without having had any prenatal care dropped from 12 percent to 6.5 percent, according to Marion Slatin, the project's chief nurse.

The project, which is supported by the Children's Bureau, provides free prenatal care to women of low income or at high risk of suffering a pregnancy casualty. The care includes laboratory work, X-rays, physical examination, dental care, medications, and instructions and other counseling.

To find ways of making the project effective in attracting women to prenatal care, the chief nurse held postpartum interviews at the hospital in 1965 with 64 of the 85 women who delivered there that year having had no such care. Nineteen gave no reason for not seeking prenatal care or said they felt it was not important; 45 gave specific reasons such as lack of a babysitter (9), money problems (8), inability to get away from work (6), newness in the community (6), transportation

difficulties (3), fear of examination (3), and other problems (10).

As a result of the interviews, the project hired a babysitter to care for patients' children in a playroom at the prenatal clinic. It chartered a bus to carry the mothers from their neighborhoods to the clinic, but because only a few patients used the service, it later substituted the provision of taxi or bus fare for mothers with transportation problems, a less expensive method. It also opened two satellite clinics in the neighborhoods where the patients live, using the same staff members who operate the maternity clinic at the hospital.

Interviews conducted with 16 of the 18 mothers delivered at the hospital

between June and October 1968 without having had prenatal care revealed that unfamiliarity with community resources because of the recentness of arrival was now the chief barrier to the receipt of prenatal care; 6 of the 16 mothers cited newness to the community as the reason they had not had such care. Five mothers gave no reason; two cited fears; and three cited premature deliveries or plans to move from the city.

Rubella vaccine

The Department of Health, Education, and Welfare on June 10 issued the first U.S. license for a live attenuated

rubella (German measles) vaccine Merck Sharp & Dohme, West Point, N.J. The vaccine, which uses the HPV-rubella virus strain developed by scientists at the National Institutes of Health, has been given to more than 18,000 children and adults in community testing in this country and abroad in the past 2 years.

The Public Health Service Advisory Committee on Immunization Practices recommended in May that the vaccine "should be given to boys and girls between the age of 1 year and puberty. No pregnant woman should be given the vaccine and immunization of adolescent girls and adult women should not be undertaken routinely."

guides and reports

ONE-PARENT FAMILY: perspectives and annotated bibliography. Benjamin Schlesinger. University of Toronto Press, Toronto 5, Ontario, Canada. 1969. 132 pp. \$5.

Contains three papers on problems and types of one-parent families and research considerations in regard to them in addition to the bibliography.

ALCOHOLISM AND FAMILY CASEWORK: theory and practice. Margaret B. Bailey. Community Council of Greater New York, 225 Park Ave. South, New York, N.Y. 10003. 1968. 162 pp. \$3.

Presents the contents of a training course on the nature and treatment of alcoholism developed for the casework staff of three New York family service agencies.

LEARNING TO APPLY NEW CONCEPTS TO CASEWORK PRACTICE: a staff development seminar. Edited by Gertrude Einstein. Family Service Association of America, 44 East 23d St., New York, N.Y. 10010. 1968. 135 pp. \$6.25.

Contains the theoretical papers, case presentations, and staff discussions of

an inservice training program focused on crisis intervention, the application of role theory and systems theory, and family group diagnosis and treatment.

LIVING WITH CHILDREN: new methods for parents and teachers. Gerald R. Patterson and M. Elizabeth Gullion. Research Press, Box 2459, Station A, Champaign, Ill. 61820. 1968. 120 pp. \$2.50.

In a programmed form of instruction, presents a method of encouraging desirable behavior and eliminating undesirable behavior in children; a guide for professionals in using the booklet with parents is available.

VOLUNTEERS LOOK AT CORRECTIONS: report of a survey. Joint Commission on Correctional Manpower and Training, 1522 K St., NW., Washington, D.C. 20005. 1969. 30 pp. \$1.

Reports on the findings of a national survey of 541 volunteers working in correctional institutions, probation and parole agencies, and volunteer courts for juveniles and adults—their characteristics and their attitudes toward and involvement with the agencies.

CHILD PROTECTIVE SERVICES AND THE LAW. Thomas T. Becl. Children's Division, The American Humane Association, P.O. Box 1, Denver, Colo. 80201. 1969. 24 pp. cents.

Examines the possible impact on neglect proceedings of two recent decisions of the Supreme Court of the United States requiring due process of law in juvenile delinquency proceedings those handed down in the Gault and Kent cases.

NUTRITION AND INTELLECTUAL GROWTH IN CHILDREN. The Association for Childhood Education International, 3615 Wisconsin Ave. NW., Washington, D.C. 1969. 63 pp. \$1.25.

Presents papers on such subjects as hunger in America, nutrition and intellectual development in children, maternal diet, growth and behavior, and role of the school in providing nutrition.

THE TEENAGER AND VIOLENCE: a social symptom of our times. Celia Deschin. Richards Rosen Press, 129 East 21st St., New York, N.Y. 10010. 1969. 130 pp. \$4.

Discusses the nature of venereal diseases, the problems of rising incidence among adolescents and their relation to the changing social climate and includes a list of audio-visual aids.

BOOK NOTES

THE MULTI-PROBLEM DILEMMA: a social research demonstration with multi-problem families. Edited by Gordon E. Brown. Scarecrow Press, Metuchen, N.J. 1968. 189 pp. \$5.

This book presents the "case history" of a research project that produced . . . an unsettling result." The objective of the project, which has come to be known as "the Chemung County study," was to assess the effects of intensive social casework with 50 "multi-problem" public assistance families, as compared with the effects of "normal public assistance services" given to 50 similar families. The conclusion was that "while the demonstration group attained a slightly better degree of family functioning, its margin of progress over the control group was not significant in the statistical sense."

The book includes a history and report of the study itself and commentaries on its implications for social work education, the practice of social casework, research in social work, and social policy regarding the kinds of families involved. Included also are excerpts from a seminar discussion of the study and the commentaries by "knowledgeable, experienced, thoughtful and articulate" participants.

In the course of the papers and the discussion, few criticisms are leveled at the research techniques of the study. More attention is given to some widespread assumptions about the social casework, especially its ability to substitute for the meeting of subsistence needs; the characteristics and needs of "multi-problem" families; and the need for realism and clarity about problems to be attacked, changes to be effected, and appropriate targets of change. Several recurrent themes of the seminar converge in Helen Harris Perlman's summary comment that "what casework can and cannot be expected to do must be thought out and spoken clearly. And along with this we must come grips with what changes or shifts in theory, stance and practice opera-

tions may be necessary if we are to fit our actions to the special characteristics of special groups of people."

THE NON-VERBAL METHOD IN WORKING WITH GROUPS. Ruth R. Middleman. Association Press, New York, N.Y. 1968. 285 pp. \$6.95.

Nonverbal communication can be used in the practice of social group work to help both the group and the individuals in it gain new insights and skills, according to the author of this book. A social work educator and consultant in group work to social agencies, she maintains that creative use of nonverbal forms of program activities is a skill that can be mastered by any thoughtful persistent practitioner.

In an activity program, "the primary method of communicating begins with and is related to some kind of action," the author explains. She tells how to analyze the values of nonverbal content of such programs, presents an analysis form for identifying patterns, and gives a number of exercises using the analysis form.

The use of nonverbal activities to achieve specific groupwork goals is illustrated by 80 case vignettes taken from groups of all ages, although more than half represent experiences with young children or teenagers. A bibliography of program resources is also included.

THE ROLE OF THE FAMILY PHYSICIAN IN AMERICA'S DEVELOPING MEDICAL CARE PROGRAM: a report and commentary. James E. Bryan. Warren H. Green, Inc., St. Louis, Mo. 1968. 57 pp. \$2.

The new family physician should be trained to "comprehend the health needs of a whole person, be the captain of the medical team, and command all the instrumentalities available to meet those needs," says the author of this book, which is based on conferences sponsored by the Family Health Foundation of

America in 1965, 1966, and 1967. Emphasis is placed on the need of every person for a personal physician who can integrate all medical and related services and insure continuity of care.

Among other topics, the author discusses the vanishing general practitioner, the family physician as a functional specialist, medicine and the hospital, and university and graduate medical education.

FACES OF THE ADOLESCENT GIRL. Lillian Cohen Kovar. Prentice-Hall, Inc., Englewood Cliffs, N.J. 1968. 178 pp. \$4.95.

This book describes behavior patterns of five types of adolescent girls—the peer-oriented, the adult-oriented, the delinquent, the anarchic bohemian, and the autonomous—and the paths they follow in the process of becoming women. The author, a sociologist with the William Alanson White Institute in New York, observed 79 high school age girls in three mental hospitals in New York City and a control group of 72 suburban and city girls. The autonomous girl who can think and feel for herself is the model adolescent, Dr. Kovar says; it is her thesis that only the autonomous girl is mentally healthy.

THE COMMUNITY'S CHILDREN: long-term substitute care: a guide for the intelligent layman. Edited by Jessie Parfit. National Bureau for Co-operation in Child Care (England) in association with Humanities Press, 303 Park Ave. South, New York, N.Y. 10010. 1968. 108 pp. \$2.75.

Information about the kinds of child care available in Britain outside of the child's own home is presented in this book, which was prepared at the request of the Association of Child Psychology and Psychiatry by a working party of 11 professional people. It discusses attitudes on child care of parents, children, residential staff members, child care officers, and foster parents; special needs of "lost and failing" children; services and training available for child care workers; and the future of child care. The editor concludes, "The establishment of an integrated child care and family service, which gives casework support to children and parents both when they are together at home and when they are separated, is essential."

READERS' EXCHANGE

GROB AND VanDOREN: *Satisfaction and regret*

In their article, "Aggressive Group Work With Teenage Delinquent Boys" (CHILDREN, May-June 1969), Grob and VanDoren show extremely well how two social group workers were able to convey their sense of respect and caring to institutionalized delinquent boys by *working with them* and by letting them *experience* cooperation, ways of getting along with others, problem-solving (how does one remove a tree stump?), and creativity through trying out their own ideas in the use of tools. The youngsters also *experienced* the need for setting limits on their own behavior—not because of some adult edict—but because of the danger involved in handling tools or working in extremely hot weather.

It is refreshing to read of social workers literally "getting their hands dirty" by participating in the activities they expect of the young people with whom they work. Group workers have been ridiculed, considered "unprofessional," and frequently rejected by others in their own profession because they did not exclusively adhere to the "verbal model" created by casework.

At present, we hear an outcry for genuine respect from groups of people in our society that feel demeaned and misunderstood by many professionals. This should help to convince social work that it has long had gold in its backyard in the form of group work, an approach to human problems based on concepts that such people demand: participation in decisionmaking; *experiencing*, not only talking, about human relations; understanding of nonverbal communication; and emphasis on mutual aid. In describing such group work concepts and principles in practice, the article by Grob and VanDoren arouses in this reader satisfaction, hope, but also regret—regret that it is still necessary in the correctional field to prove that one must treat people like human beings.

It is tragic that harassment and

ridicule still are being used in work with young people. It is also tragic that institutions are still run on the premise that youngsters will become better members of society when they are made to conform and are not involved in any decisionmaking. Social workers often maintain that they are in the forefront of social reform. Yet, in the institutions where they are almost "kings," they have frequently been unable or unwilling to realize the most basic principles of human dignity. There *are* institutions, of course, that have used those principles. Yet, in the late 20th century, there should be *none* where one still must demonstrate that being treated with respect is essential to help our young delinquents. One can only ask with despair, "If not now, when?"

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HUGHES: *A child welfare service*

In her article, "Services to Children Living With Relatives or Guardians," Shirley L. Hughes provides a convincing example of the need for child welfare services by children in the public assistance caseload. (CHILDREN, May-June 1969.) She describes how, under stimulus of the 1962 amendments to the Social Security Act, the Baltimore County Department of Social Services has been providing special attention to children in the AFDC program who are living away from their parents with relatives or legal guardians.

The article is of value also because of its description of some of the requirements for providing casework service effectively: caseload size related to function and method; recognition of the advantages of specialization of tasks for better quality and accountability; the importance of a thorough preliminary study; intensive activity to meet immediate needs and to establish a relationship with the client.

What Miss Hughes has described seems to be the development of a child welfare service within the public assistance division in her agency. If this is true, it raises questions of the organization and availability of child welfare services elsewhere in the agency or in the community and the concept that govern those services.

The apparent practice of the court in Baltimore County of relying on relatives and other persons as guardians or parent surrogates, would seem to indicate a failure by child welfare agencies to offer sufficient, or sufficiently broad based, services to the court to meet the needs of children coming before it. True, in many of our communities foster care, when needed, is not easily available either to courts or to parents by their own direct application, yet the problems described in Miss Hughes' article are those that can often be prevented with timely counseling of parents coupled, when necessary, with foster care.

My comments on service organization should not obscure the sense of responsibility that the Baltimore County agency demonstrated for a group of children frequently overlooked in child welfare services, a group that exists not only among the poor. At all levels of society relatives or unrelated persons acting as parent surrogates may assume a responsibility for children reluctant or with a mistaken understanding of the implications. Many parents, no longer able to provide a home for their children, need the help of child welfare services in making plans and decisions and understanding alternatives and their implications, and children aware from their parents need continued services.

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children

Black Identity and the Service-Giver

A Hotline for Adolescents in Crisis

Teamwork in Child Psychiatry

Reaching Families of Delinquent Boys



children

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

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Schooldays for many children, like these two boys, bring opportunities for getting to know one another, thus laying the groundwork for mutual acceptance and often for lasting friendships undisturbed by racial consciousness. But when people of different backgrounds have never come together on equal terms, their external differences loom large and become the basis for profound suspicion, if not complete rejection—making relevant the kind of study described in the first article in this issue.

children

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The growing emphasis in this country of "black identity" raises many important questions for agencies in the fields of health, education, and welfare. The large demand in the innercity areas for maternal and child health service and for public assistance under the program of aid to families with dependent children makes the following questions of special interest to agencies serving mothers and children. Do residents of black innercity neighborhoods consider competence more important than race in the provision of services? Are white members of service staffs still welcome in black neighborhoods? Is the preference in these neighborhoods for black service-givers great enough that white persons ultimately will not be accepted? If so, would public agencies be able to comply with the Civil Rights Act? These questions are of interest not only to service agencies but also to professional schools, since their students—black and white—often serve as interns in the inner city.

In their discussions of these questions, white professional persons and black community leaders often express widely differing views that are rarely reported in print. Except for the results of a small study conducted in Cleveland, Ohio, virtually no data exist on attitudes of black persons seeking or receiving service.¹

The University of Chicago School of Social Service Administration, with support from the Children's Bureau, in 1968 conducted a feasibility study of the operations of a social services center. One part concerned the preferences of the residents of a black neighborhood in Chicago regarding the race and competence of persons providing them with services. The rationale was that agencies planning or providing services need to be aware of the attitudes of the people they intend to serve.

The opinions in the neighborhood under study may or may not be typical of other neighborhoods and probably vary from time to time. Also, in an opinion research, expressed opinions may not always be valid indicators of actual opinions or future conduct. Respondents may tell the interviewer what they think he wants to hear. Those who say they will not accept service from a white person may or may not actually refuse to be served by a white

Eight social work students assisted in the design, data gathering, and analysis of the study reported here—Merle Becker, Robert Grimm, James Kallmyer, Bernard Hannon, Vivian Losey, Mary McDavitt, Ruth Chitlik, and Patricia Steiner. Esther Silverman supervised the data analysis.

BLACK IDENTITY

and the HELPING PERSON

DONALD BRIELAND

person, depending upon the strength of their conviction and the intensity of their need for service. The School of Social Service Administration has plans to repeat the study in at least one other neighborhood, and perhaps more, with different kinds of civil rights activities and interracial services. Its method may also be useful for similar studies in other cities.

Method and sample

Thirty-eight items were developed as a questionnaire to be administered in a 10-minute interview with each participant. Six items had to do with identifying data such as place of birth, age, sex, and length of residence; 32 items were concerned with the participants' experience with services and their attitudes toward the race of the persons giving them.

The study was conducted in the Woodlawn area of Chicago's South Side, a neighborhood inhabited by persons of low income, 98 percent of whom are black. The sample included 380 black persons—85 men and 295 women. All participants were seeking or receiving service from at least one Woodlawn social or health agency.

The participants were told that questions were being asked of Woodlawn residents so that "more effective services could be developed for a new center being planned." Each person was assured that participation was completely voluntary and that he did not have to give his name. Less than 5 percent of the persons approached refused to participate.

The participants were selected at random from persons waiting to see staff members in two public

aid offices, an Urban Progress Center supported by the Office of Economic Opportunity, a maternal and child health station, and a legal aid office. More women were available than men, since the agencies operated during hours when men are usually at work. The number of interviews in each of the locations ranged from 52 at the legal aid clinic to 109 at the Urban Progress Center.

The sample was composed predominantly of younger adults; 304, or 80 percent, were under 40—170 were between 20 and 29, 88 were between 30 and 39, and 46 were under 20.

About 60 percent of the persons interviewed were born in the South and 35 percent in Illinois. Their length of residence in Chicago varied widely. Thirteen percent had been in Chicago fewer than 5 years, but 17 percent had been in the city 30 years or more. Eighteen percent had lived in the Woodlawn neighborhood less than a year, but 59 percent had lived there from 1 to 9 years.

Because race of the interviewers could be an important variable in the study, both black and white interviewers were used and a large enough sample of respondents were included to make a valid comparison of their findings. Black interviewers conducted 291 interviews and white interviewers, 89. Data gathered by black interviewers and white interviewers on questions involving attitudes were analyzed separately and compared.

Another variable might be the participant's racial self-referent—the term he uses to designate his race. Therefore, the participant was asked which term he preferred—"black," "Negro," or "colored."

Table I.—RACE PREFERENCE FOR SERVICE-GIVERS
(percentage distribution)

Preference	Doctor		Caseworker		Teacher		Lawyer		Parent group leader	
	WI	BI	WI	BI	WI	BI	WI	BI	WI	BI
Black.....	18	66	17	55	13	55	15	51	27	64
White.....	8	11	25	24	8	10	16	26	7	5
No preference.....	74	23	58	21	79	35	69	23	66	31

WI= White Interviewer
BI= Black Interviewer

The term selected was used by the interviewer in asking all subsequent questions that required the participant to choose between one race or the other. The point was to discover not only the popularity of the newer term "black," but also whether persons choosing "black" had different preferences than others in regard to service-givers.

Issues and findings

Self-referent. In response to the question "Which term do you prefer?" 53 percent said "Negro," 24 percent "black," 19 percent "colored," and the rest "no preference." Preferences were not significantly associated with the race of the interviewer or the ages of the participants. Also, those who preferred the term "black" did not have a stronger preference than others for being served by black persons.

Service experience. Questions were included regarding the participant's actual experience with five types of helping persons—physicians (referred to as "doctors"), caseworkers, teachers, lawyers, and leaders of parents' child-care discussion groups. Very few of the respondents had had experience with more than three of the five kinds of service-givers, but nearly all had had experience with more than one type.

Doctors. Half the persons interviewed did not have a private physician. The rest had received some service for their families in medical clinics where there was no choice of doctor at the outset, though some clinics tried to have the patient see the same doctor for a series of visits. Twenty-two percent of those interviewed had private physicians who were black and 22 percent had private physicians who were white.

Four percent said their families were served by private physicians of both races. Two percent said they were served by private physicians but did not indicate race.

Caseworkers. Fifty-three percent had never been served by a social caseworker. Twenty-four percent had been served by a black caseworker and 19 percent by a white caseworker. One percent had been served by both black and white caseworkers and three percent did not indicate race. About one-sixth of the sample had received casework service for less than 6 months. The same proportion had received it for more than 2 years. Among the latter group, turnover of caseworkers was often mentioned as a problem. The participants' interpretation of social casework clearly included service from public assistance workers.

Lawyers. Sixty-seven percent had had no legal service in the last 5 years. Ten percent had had a black lawyer and 21 percent a white lawyer. Lawyers of both races had been used by 2 percent. These percentages included both lawyers in private practice and lawyers provided by a legal aid service.

Teachers. Forty-six percent had no children in school at the time of the study. The children of 11 percent of the total sample had been served only by black teachers and 3 percent only by white teachers. Thirty-five percent had had teachers of both races. Two percent did not indicate race and 3 percent did not know.

Parent group leaders. Sixty-eight percent of the persons interviewed had not attended any parent groups—a smaller percentage than the study planners had expected. Ten percent had participated in such group discussions with a black leader, 2 per-

Table II.—MAJOR REASONS FOR RACE PREFERENCE FOR SERVICE-GIVERS
(percentage distribution)

Service personnel	Racial identification	Understanding of problems	Competence	Miscellaneous
Doctor.....	34	13	27	26
Caseworker.....	18	32	21	29
Teacher.....	16	20	31	33
Lawyer.....	21	14	24	41
Parent group leader.....	16	32	23	29

cent with a white leader, and 20 percent with leaders of both races.

The data on experience with service suggest that the participants' actual contact with service personnel of the two races differed considerably from one type of service to another. As many had been served by white as by black private physicians. Experience with both races was most common in the case of teachers. Only one-third of the participants had had any experience with lawyers, but among those who had, the lawyers usually had been white.

Service persons preferred. The interviewers asked the following question in referring to each of the five types of service-givers: "If both were equally good, would you prefer that they be Negro (black, colored) or white?" All but 2 percent of the persons interviewed responded to this question, but there was a greater tendency to hesitate in answering among the participants who had white interviewers. Table I presents the results.

Responses to white interviewers piled up in the "no preference" category. Respondents having black interviewers showed a preference for being served by black persons from 2 to 4 times as great as those who had white interviewers, the size of the difference depending upon the type of service under consideration. For each of the helping professions, the odds are less than one in 1,000 that the differences between responses to white and black interviewers would occur by chance.

The strongest preference was expressed for black physicians and the least for black lawyers. However, a majority still favored black lawyers. The highest percentage of "no preference" was for teachers.

The participants were then asked why they preferred to be served by persons of the race they designated. Data on reasons for preferences must be interpreted carefully. Asking a person why he expresses a certain preference stimulates responses without indicating their intensity or validity. Some people state reasons that reflect their basic values, but others come up with superficial answers just to have something to say. With a wide range of responses, there also is difficulty in categorization.

Three general classifications were developed in analyzing the findings: racial identification; emphasis on understanding personal problems; and technical competence. The rest of the responses constitutes a miscellaneous group, since they could not be coded. Obviously, the latter two place no primary emphasis on race. In the case of racial identification, the subject wanted to be with members of his race, liked black people better, felt more at ease with them, or wanted them to provide the service because he believed in patronizing members of his own race. The second classification stressed the need for someone who had had similar experiences to the participants and therefore understood him. The third referred to the skill of the service-giver.

Findings differed for the various helping roles as can be seen in table II. Although the questions asked preferences as to race among service-givers who were equally skillful, competence was still a major element in the statement of reasons for preference.

Importance of qualifications. Those who preferred to be served by black persons were then asked for each type of service, "Would it make a difference in your choice if a white person were better qualified?"

Table III.—PERSONS PREFERRING SERVICE FROM BLACKS FOR WHOM QUALIFICATIONS WOULD ALTER CHOICE
(percentage distribution)

Qualifications alter choice	Doctor		Caseworker		Teacher		Lawyer		Parent group leader	
	WI	BI	WI	BI	WI	BI	WI	BI	WI	BI
Yes.....	94	83	93	74	100	69	92	76	70	
No.....	6	17	7	26	0	31	8	24	30	

WI= White Interviewer

BI=Black Interviewer

Competence proved to be more important to the respondents than race, regardless of the race of the interviewer, as can be seen in table III.

In all categories except parent group leader, over 90 percent of the respondents interviewed by white persons said that qualifications would make a difference in their choice. In responses to black interviewers, the range was from 63 to 83 percent in favor of competence. Only about 10 percent of the total sample made the choice in terms of race in spite of qualifications, except in regard to parent group leaders. For that category, the percentage still preferring to be served by their own race was doubled, but, nevertheless, was only 20 percent.

Acceptance of service. Another series of questions on the race of service-givers was asked only of persons who said they preferred to receive service from members of their own race: "Would you accept service from a white person?" Only 30 persons or 8 percent of the total sample said "No." Two persons said they would not accept service from a white person in any of the five professional roles, three rejected whites in four roles, one in three, six in two, and 18 in one. Rejection was greatest for white parent group leaders, with 25 persons answering "no" in their regard, and least for white caseworkers and physicians, with only six and five persons respectively answering "no." Eleven persons said they would reject white teachers; only eight would reject white lawyers.

The questions on preference were analyzed to discern the attitudes of the 58 subjects who had had

more than 2 years of social casework service. Twelve had been interviewed by white interviewers and 4 by black interviewers. The effort was to learn whether a relatively long experience with a helping service made any difference in the respondents' preferences concerning the race of the serving person. The responses to the black interviewers showed that among persons who had had 2 or more years of casework service, 41 percent preferred having a white caseworker; 33 percent, a black caseworker; and 26 percent had no preference. And among the 149 respondents who had had less than 2 years of casework service or none at all, 59 percent said they would prefer a black caseworker; 21 percent, a white caseworker; and 20 percent had no preference. The number of persons interviewed by white interviewers was too small for such a comparison.

Thus, 2 years or more of casework service is associated with a significantly smaller preference for black caseworkers, but this is true only of such long

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Table IV.—CHARACTERISTICS OF SERVICE-GIVERS
(percentage distribution)

Race of helping person	Best knows meaning of poverty		Expects more gratitude		Gives more feeling of hope		Makes people feel they don't amount to very much		Talks down to people		More interested in your problems	
	WI	BI	WI	BI	WI	BI	WI	BI	WI	BI	WI	BI
White.....	12	8	48	53	37	31	40	66	49	66	36	22
Black.....	78	87	31	43	52	63	34	28	29	28	51	75
It depends.....	10	5	21	4	11	6	26	6	22	6	13	3

WI= White Interviewer

BI= Black Interviewer

term service. Dividing the rest of the sample into persons who had some casework service, but less than 2 years, and those who had none showed no differences in preferences. The study did not obtain data for a similar analysis of the other professions.

Characteristics of helping people. The respondents were asked several questions concerning their opinions of the characteristics of service-givers.

"Even though there may be only a slight difference between them—

"Who understands better what it means to be poor, Negro (or other preferred term) or white?"

"Who expects people to feel more grateful to them?"

"Who gives people more of a feeling of hope?"

"Who makes people they help feel that they don't amount to very much?"

"Who talks down to people?"

"Who is more interested in your problems?"

The results are summarized in table IV.

In each case, the majority chose black persons for the more favorable answer. Although this choice was more common for the group interviewed by black interviewers, the differences in responses according to the race of the interviewer were not statistically significant. The greatest consensus was obtained on blacks' "best knowing the meaning of being poor" and the least consensus on "who expects more gratitude." In this, as in other aspects of the study, the black interviewers received fewer indefinite responses.

In general, these results indicate that black people seeking or receiving service in one low-income

black neighborhood prefer to be served by members of their own race, all other things being equal. But when competence is introduced as a factor, it becomes more important in determining preferences than does race. The race of the interviewer affects results, the black interviewers eliciting significantly fewer undecided responses and stronger preferences for black service-givers.

Implications of study

This study does *not* show that white helping persons are unwelcome in black neighborhoods. However, the results suggest the need to provide black service-givers in service agencies—especially so to serve persons who reflect the community leadership's concern with the development of pride in black identity. It also emphasizes for white people who work in predominantly black neighborhoods the importance of being sensitive to the broad implications of the emerging emphasis on black identity.

The study came up with a rather complex set of results. Not only does it show that strength of preference for black people as service-givers differs from one service role to another, but also that the proportion of rejection of whites also differs among the roles. These differences suggest that each agency must look at its own situation not only in relation to the kind of personnel it has and the clients it serves but also in relation to the goals of the community leadership. The study also reinforces the importance of competence as the first requirement in selection of staff members.

In an effort to pinpoint the implications of the study, the School of Social Service Administration submitted the findings to a number of service agencies in Chicago, particularly to those providing services in the Woodlawn area, and followed this up with meetings with agency administrators and staff members to discuss the study's findings in relation to their experiences in providing services. In general, surprise was expressed at the high level of preference for black service-givers, but not at the other results. Many of the agency persons said they could have predicted that competence would be regarded as more important than race. As one person said, "Black identity was clearly within the awareness of the subjects, but they did not let it get in their way in their quest for effective service."

None of the agency representatives reported having noted any growing expression of a desire on their clients' part to be served by members of their own race. Only rarely, apparently, had such a request been made. Persons who work in a legal aid service said that occasionally a black client would request a white lawyer "because the courts are white."

There seemed to be general recognition among the participants in these discussions that in therapeutically oriented services, such as social casework, it may occasionally be necessary to assign a client a worker of the race he requests to provide effective therapy, but opinions differed greatly on the importance of race in most such situations.

Members of both races said they would be reluctant to recommend that their agencies transfer a black client's case from a white to a black worker at the client's request, because if black clients were allowed to refuse to be served by a white worker, white clients would be free to refuse to be served by black workers. Many of the participants in the discussion pointed out that the legality of assigning workers according to race would be questionable under the Civil Rights Act.

Besides the problems that would arise under the Civil Rights Act if racial preferences were used as the basis for assignment, the agency staff members pointed out that the pools of applicants for positions as public aid workers and as schoolteachers in Chicago had become increasingly white as job opportunities outside the educational and public welfare

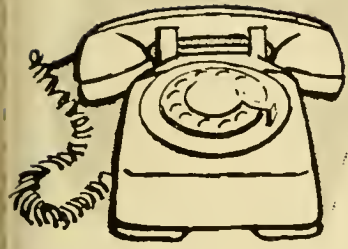
fields have expanded for educated black persons. They said they anticipate an increasing shortage of black persons for such service positions. The consensus seemed to be that more black persons should be employed in these fields than at present and the most promising way to get more in would be to develop service roles and career ladders for persons from low-income neighborhoods who have less formal education than is required for public aid workers and teachers, since for some time there will not be enough black professional workers to meet the demand. Some persons suggested that the symbolic value of having black persons in key administrative positions would make an interracial supervisory and service staff acceptable to race-conscious black community leaders.

The general feeling evident in these discussions was that agencies had not been greatly concerned with the issues studied because clients had not made demands relating to the race of the service-givers. Many of the participants said that the study opened up questions that needed consideration and that would loom more important in the future. They said they would like to find out whether the findings were unique to Woodlawn, where an influential community organization, the Woodlawn Organization, has gone on record that black people should determine the policies of the agencies that serve them, but that in the interest of good service white persons would be acceptable to work with them in the agencies.

The discussants agreed that this was the prevailing view in the Woodlawn community but that studies in other neighborhoods might show greater militancy. They strongly favored repeating the study in other areas but with black interviewers only.

THE GROWING EMPHASIS on black identity should provide a significant line of research in the fields of health, welfare, and education for the next few years. Agency decisions are more realistic when based on collected data than when based on hunches and stereotypes.

¹ Dubey, S. N.: Blacks' preference for black professionals, business and religious leaders at a community level. School of Applied Social Sciences, Case Western Reserve University, Cleveland, Ohio. 1969. (Unpublished report.)



a hotline telephone service for young people in crisis

One of the major reasons that young people today find themselves alienated from what they call the "establishment" of the "system" may be the increasingly wide gap between them and the helping agencies. Long waiting periods, unavailability of service when needed, the categorizing of persons by their complaints, and the fragmentation of services make it difficult for many adolescents to use the services that do exist for them. Added to these deterrents to the use of service are young people's characteristic reluctance to regard themselves as problems, their unwillingness to wait for help if it is not immediately available when crises arise, and their general lack of knowledge about existing services.

In an effort to help young people break through these obstacles to securing help when they need it, the Childrens Hospital at Los Angeles is providing an emergency telephone service for adolescents and young adults under 25. Called the Hotline, the service was established in April 1968 as a resource for helping young people in a time of crisis by making an understanding, objective, and informed listener as close as the nearest telephone. Over 7,000 telephone calls were received from young people during the service's first year.

When the Hotline was first proposed, several questions arose. Would young people use the service? What types of problems would they present? Could all the phone calls be answered? Who should answer the phones? How would the telephone answerer be trained for the task? What about followup, community resources, and funding? Through a series of meetings with representatives of other services in the community, the hospital established an advisory board to consider these questions. This committee

still meets monthly to discuss policy issues and program needs.

Support for the program was obtained from the California Department of Health, the Rosenberg Foundation, and private donations. To man the telephones, persons were sought who could communicate easily with young people in an open and sensitive way, who were not easily put on the defensive, and who were not authoritarian or judgmental in their responses. Each applicant was interviewed independently by two professional members of the advisory board.

When the staff was selected and the service was ready for operation, four young people, with approval of the school authorities, distributed 10,000 cards calling attention to the Hotline to young people on the campuses of four local high schools. A local newspaper also carried a notice of the program.

The service operates every night of the week, including Sunday. The usual hours are from 6 p.m. to 12 midnight, but on Friday and Saturday nights the hours are extended until 2 a.m. At all times during the service hours, three staff members are on duty to answer calls on four incoming lines, which are linked to a rotary mechanism. The switchboard is also equipped to permit an incoming call to be transferred to consultants available in mental health, medicine, probation, religion, community resources, or law. In this way, a three-way conversation (or "patch-in") is possible when indicated by either an emergency situation or a staff member's wish to consult a specialist. The telephone numbers of several consultants in various fields of service are kept in the Hotline office, as well as the numbers of community agencies that serve as resources.

A HOTLINE CONVERSATION

Listener: Hello, this is Hotline. My name is Linda. Can I help you?

Caller: Well, I've been thinking lately that I'd like to try some "pot" (marijuana). Do you think I should?

Listener: I take it you're not so sure whether you want to or not?

Caller: Well, I don't see what's wrong with it. All the other guys are; they've been taking it a long time.

Listener: How's it happened you've gone along this far without having tried it yet?

Caller: I've thought about it a lot.

Listener: What are some things you've considered that make you hesitate?

Caller: I read somewhere that you can get hooked or it could change my brain. What do you think?

Listener: Well, right now I'm wondering about other things you may have thought of that make you uneasy about trying it.

Caller: Well, it seems like everybody's doing it and I want to be an individual.

Listener: Do you think it's real important to be an individual?

Caller: Yea, like it's really hard not to do what everyone else is doing. Do you know what I mean?

Listener: Yes, I think I do—like drugs, for example, seems like a lot of people are taking them and that this would be particularly difficult to stay away from—there could be a lot of pressure.

Caller: What would you think if I told you I've already taken drugs?

Listener: Well, then I might wonder if this has been bothering you.

Caller: Well, actually that's really why I called. Can you help me?

Listener: Do you mean you'd like to stop?

Caller: Yea.

At this point, the listener asked the caller if he had tried to stop, and, if so, how. The reasons these attempts had failed were explored and other possible approaches were considered by the two of them together in an extended discussion between them.

In addition, the clinic employs an answering service that takes messages from young people when they call outside regular hours. These calls are referred to members of the clinic staff during the day or members of the Hotline staff when they come on duty, and, if the situation seems urgent, a worker contacts the caller. Thus, 24-hour coverage is achieved.

The staff consists of 30 young persons, most of them in their 20's, who have various types of background. A number of them are graduate students in medicine, social work, or psychology. Working in teams of three persons per shift, they are paid \$15 each for 6 hours of work. All staff members receive some preliminary training as well as training on the job. Before beginning work, each staff member attends two formal 3-hour sessions. Subjects discussed in these sessions include the youth culture, the drug and hippie scene, venereal disease, laws relating to juveniles, and community resources for providing help. The new staff members are helped to understand general principles of interviewing and of crisis intervention through role-playing and answering simulated telephone calls.

Training is a continuous process. All staff members attend regular meetings with the program's supervisors to learn techniques of dealing with callers, review the principles of the service, and discuss actual calls that raise questions or that exemplify problems for the staff. In addition, the training supervisors make periodic visits to staff members on duty to provide individual consultation.

At all times the caller's desire for anonymity is respected. He is not asked to give any information about himself. However, callers frequently describe themselves voluntarily in presenting their problems. The staff's approach to assisting callers is based upon a number of assumptions:

1. Those who call the service do so because they face some conflict or uncertainty that they have not yet been able to resolve on their own.
2. Effective resolutions of problems can only evolve out of the context of the individual's own experience.
3. Persons with problems benefit little, if at all, from direct advice, readymade solutions, or any kind of action that displaces responsibility.
4. Unconditional concern and respect for the caller, effectively communicated to him, are prerequisites for constructive interaction between the staff member and the caller.

A directory of community agencies—hospital, police, public health, and mental health—is kept on hand in the Hotline room at the hospital to help the staff refer the caller to the best place for securing the kind of help he needs. A catalogue of resource material, including information about frequent prob-

lems among teenagers and current fads in teenage language, is also kept there. Information on every call is recorded; all completed data forms are kept on file in sequence, and a separate file is kept for frequent callers.

Callers and problems

The data obtained from each call are coded and fed to a computer through the facilities of the Youth Study Center of the University of Southern California. We have recognized from the start that our attempts at evaluation will be limited by the anonymity of the callers, the program's emphasis on service rather than research, and the problems encountered in getting such a program underway. Therefore, in analyzing the results of our first 3 months of operation, we addressed ourselves to two basic questions: Would adolescents use an emergency telephone service? What kinds of problems would they present?

The answer to the first question was a decided "yes." During its first 3 months of operation, the service received 1,071 calls from 872 persons—an average of 19 calls a day. The busiest times were on weekends when the average was 25 calls a day. The calls lasted from 1 minute to 3½ hours. The average duration was 20 minutes, but the most frequent duration was about 10 minutes.

No information is routinely requested during the Hotline calls. However, a great deal of data is frequently volunteered. Of the first 872 callers, 516 gave their age. They ranged in age from 13 to 35 years, but most of them were between the ages of 13 and 20. The average age was slightly over 17. It was 16.8 for females and 17.7 for males. There were nearly twice as many females as males—a ratio of 1.7 to 1.

In regard to our second question, the analysis showed that the callers had presented 31 different kinds of problems or requests. The most frequent by far were problems related to boy-girl relations (nearly 21 percent of the problems mentioned) and problems related to parental conflict (nearly 19 percent of all). Other problems frequently brought up by the callers related to drug use (nearly 7 percent of all), school (nearly 5 percent), social isolation (over 3 percent), social inhibition (3 percent), and pregnancy (3 percent). A scattering of miscellaneous problems comprised 27 percent of the problems or requests recorded.

Many of the calls were concerned with information only—about the Hotline itself (nearly 6 percent of the "problems" recorded) and with other types of

information (over 3 percent). Some of the problems brought up by the callers were "put-ons" (3 percent).

The following brief illustrations show some of the specific problems that prompted young people to use the Hotline:

- A 17-year-old youngster who had shot heroin and missed a vein was in a panic as to what to do. Through the "patch-in" service, he was able to talk directly to a physician, who assured him that he was not in immediate danger.

- A 14-year-old girl who had run away from home wanted to know the legal implications of her action. Through the "patch-in," she was put in contact with a juvenile public defender who gave her the information she sought and discussed various alternatives with her.

- A 19-year-old girl called in a panic because she thought she might be pregnant. Frantic at the prospect, she was alternately contemplating marriage, suicide, or abortion. She was referred to a local public health agency for a medical examination and pregnancy test. Later she called back to say that the examination had revealed that she was not pregnant.

- A 14-year-old boy and his mother called in together on extension phones asking the Hotline operator to mediate a heated argument. After some discussion, they saw how ineffective it was for them to be talking to each other by phone from separate rooms when they could be talking out their differences face to face.

In instances of acute medical emergencies when the life of the caller may be at stake, as in contemplated or attempted suicide, efforts are made to find out the location of the caller and to intercede.

Conclusions and questions

On the basis of our first year's operation of the Hotline, two facts stand out clearly:

1. Adolescents will use the emergency telephone service to discuss their personal problems in detail. We suspect that the main reasons why they do so is because of the anonymity it allows them and because the service is available to them immediately when a crisis occurs in their lives. The fact that the service is located in a hospital may also appeal to young people in trouble because of the objectivity, neutrality, and confidentiality traditionally associated with

medical services. Another reason for the frequent use of the service may be that most social agencies that help people with interpersonal and social problems do not provide service in the evening or on weekends.

2. The types of problems for which adolescents use an emergency telephone service primarily relate to interpersonal relations, especially boy-girl problems and family conflicts.

Our experience to date has raised several questions that we are planning to explore:

- Does the emergency telephone service reach young people who would not ordinarily seek help from existing community agencies?

Our impressions are that in some instances the Hotline may serve as young people's treatment for problems that are subclinical in nature, such as early pre-delinquent behavior or situational crises of adolescence that, if unresolved, might require professional therapeutic intervention. In other instances, the Hotline may help the young person identify his own needs and then direct him to the appropriate community resource for dealing with them.

- Can an emergency telephone service to teenagers also serve as a listening post for learning about pressing problems in the teenage world?

Since the population served may include many persons not likely to use the resources of social agencies, the data generated by Hotline callers may provide more valid information on the kinds of problems that teenagers face today in large metropolitan communities than such agencies can provide. If so, such information would be of value in community planning for meeting the needs of teenagers.

- How effective are our methods of dealing with the troubled teenagers who use the Hotline?

Impressions we have received from repeat calls (20 percent of the callers are repeaters) and unsolicited letters from callers suggest that the service may prove to be a valuable adjunct to other community resources for adolescents. We realize, however, that more precise information is needed to evaluate the effectiveness of our staff members' methods of helping teenagers cope with their problems and the utilization of the service by young people. Therefore, we are exploring several research techniques that promise to yield a more definitive answer to this

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question. We are now developing methods to analyze the interaction that takes place during calls and to relate the types of interaction noted to the results of the service as measured by followup reports requested of the caller and information received from the caller's school, family, and friends. Because the caller's anonymity and confidence must be respected these approaches to evaluation cannot be made without the permission of the caller.

- Is the emergency telephone service an effective training vehicle for professional persons in the health field?

Our use of graduate students to answer the incoming calls may indicate whether such experience is useful to students in developing skill in working with adolescents facing crises.

The Hotline Emergency Telephone Service represents an experiment in communicating with young people. The fact that so many people still in their teens have used the Hotline points to the need for services that reach out to adolescents who have problems without labeling them as problem adolescents. This response also suggests that the development of multipurpose youth centers patterned on the Hotline approach to the young might merit careful consideration. We know that the fragmentation of services often keeps people from using them. If our communities would provide centers where young people merely by walking in, could get health supervision, personal counseling, job placement, legal aid, or recreation, according to their needs, many more young people might seek help for their problems before serious complications developed. Moreover, the communities might find that they had built effective two way channels of communication between the "establishment" and the young.

COMPREHENSIVE CHILD PSYCHIATRY through

} a TEAM APPROACH

JOHN B. LIVINGSTONE

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SILVIO ONESTI, JR.

The team method of dealing with patients has become widely accepted in child psychiatry as a way of providing the variety of services needed, yet fragmentation of service often occurs. This paradox exists because of a number of problems that have hindered the full evolution of team collaboration into teachable techniques to assure comprehensive evaluation and treatment of children's difficulties. One obstacle has been defined as the conflict among professional disciplines about "who owns the sick child," stemming from the inability and unwillingness of people or groups to give up individual autonomy.¹ This tendency to cling to autonomy has been attributed partly to a concern about the loss of professional identity.² At the Beth Israel Hospital in Boston, Mass., the Child Psychiatry Unit has devised a special service for children based on a method of interprofessional collaboration that allows each professional person to maintain his professional identity. Furthermore, this method takes into account warnings against the danger of skill dilution³ in focusing the multidisciplinary team's attention on the physical and emotional needs of each patient.

Staff resistance is only one of several blocks to full use of collaborative methods. We discovered another at Beth Israel as we analyzed our own and others' customary team efforts to provide psychiatric and pediatric services. This block derives from each professional person's having a separate experience

with the patient and a different degree of involvement in the team's continuing relationship with the child, his parents, and other important persons in the child's life. We also found that an inadequate structure for collaboration within and between a hospital's outpatient departments discourages growth in collaboration between individuals. Awareness of these blocks to collaboration led to the policy for the new service of having the same child psychiatrist, pediatrician, social worker, and clinical psychologist take a continuing, shared responsibility for evaluating all aspects of the child's and parents' condition and devising and initiating the treatment plan.

Merely having the same group of clinicians work with the same patients, however, does not automatically result in the kind of collaboration that benefits patients. To meet a patient's needs in a comprehensive and efficient way, the collaborators must communicate effectively. Therefore, our design for collaboration includes many opportunities for exchange and discussion of clinical information. This provides for an integration of professional observation and opinion that brings the child and his parents the benefit of a true combination of professional skills.

Patients are selected by the social worker for this special service of the Child Psychiatry Unit on the basis of the urgency of their problems, the recency of the onset of their symptoms, their need for multidisciplinary attention, or the likelihood of their responding favorably to short-term treatment.

Clinic procedures

The aim of the clinic is to arrive at a comprehensive evaluation and a disposition of each case in a single 3-hour encounter of the team members with the child and his parents. Dispositions vary from termination of formal contact after a single session to continuing treatment of limited duration with specific goals. Each member of the team contributes his

viewpoint in a series of team conferences that take place during the 3 hours the family is in the clinic. Which team members see the child or his parents, when, and for how long depend on the particular needs in each case.

The majority of the clinic's work takes place in a suite of four rooms located in the hospital's outpatient department. A one-way mirror, about which the patients are informed, is used by the whole team to observe the parents and child when they are alone, or by some team members to observe another staff person's interview with them. The rooms are also equipped for physical examinations. In addition to the clinic staff, other professional persons already involved with the child and his family—the family's pediatrician, a school guidance counselor, a family agency worker—may participate in the sessions.

The general procedure followed involves (a) a pre-interview investigation, consisting of the collection of information in writing and by telephone from parents, the referring person, the child's school, and other pertinent community sources; (b) a pre-interview conference between the team's child psychiatrist and psychiatric social worker to establish a preliminary working hypothesis and plan of procedure; (c) the family's 3-hour visit to the clinic; and (d) followup, which may consist only of a telephone call or may include one or more additional visits of the child and his parents to the clinic.

The 3-hour session at the clinic includes a joint interview with the child and parents carried out by the psychiatrist and social worker; separate interviews of child and parents; a pediatric examination; direct observation of and frequent discussions about both child and parents by all team members; opportunity for family members to communicate with one another during the evaluation; and the final conference of the session in which a report and recommendations are given to the family. While the procedures are kept flexible to allow for individual needs, the model frequently followed involves the eight steps enumerated in the design on page 183.

An example

The case of 9-year-old Bob demonstrates the advantages of this collaborative method. Bob's anxious, intellectually oriented parents brought him to our clinic because he was having learning difficulties and terrifying nightmares. Six months before, fearing that he might be mentally subnormal, they had taken him to another child guidance clinic. They were told

then that the child was unusually bright and might learn better in a more advanced, liberal school than the one he was attending. Because the parents' underlying questions were not answered, they were not reassured by the news of the boy's brightness and felt uneasy about changing schools. They did not return to that clinic although offered the opportunity.

Before the family's first visit to our clinic, the child psychiatrist and social worker met together to discuss the information they had gathered about Bob and his parents. They considered the following facts, working hypotheses, and possible plans:

1. That behind the parents' concern about mental retardation was an unrelieved fear that Bob had an organic defect; that the team should investigate this issue during the evaluation; and that reassuring the parents to the contrary without a thorough pediatric assessment would be of little help.

2. That Bob was indeed having problems of his own that needed to be assessed. (Information secured from sources other than his parents indicated that he was restless in school and that he probably had a learning disability and poor relationships with other children.)

3. That the school guidance counselor, who had already developed a supportive relationship with Bob, might be drawn into the treatment plan.

In their first joint interview with the parents and the child (step 1), the child psychiatrist and social worker observed Bob's anxiety and helped the parents recognize it and their own difficulty in responding to him in a helpful way. In discussing the parents' fears about the possibility of Bob's having an organic defect, the team made it clear to the parents that this possibility would be carefully looked into during the evaluation.

Next the child psychiatrist interviewed the child in one room (step 2), while the social worker interviewed the parents together in another room (step 3). The pediatrician and the psychologist observed the child's interview through the one-way mirror. At the end of these interviews, the family had been in the clinic for an hour and 15 minutes.

At this point, the four team members met for their first case conference (step 4) during which they were all informed of the facts and impressions that had been gathered thus far. They agreed that the mother was either avoiding Bob's emotional needs or responding with rage and inconsistent discipline, and

DIAGNOSTIC MODEL

<i>Telephone referral</i>	<i>Pre-interview investigation</i>	<i>Evaluation procedure—3-hour clinic visit</i>	<i>Followup</i>	
			<i>Telephone calls</i>	<i>Possible return visit</i>
Initial facts received about the child and the problem he presents.	<ol style="list-style-type: none"> 1. Information form completed by parents and returned to clinic. 2. Telephone contacts made to referring person, school, etc. 3. Conference of child psychiatrist and social worker for first working hypothesis and evaluation plan. 	<ol style="list-style-type: none"> 1. Child and parents interviewed together briefly by psychiatrist and social worker. 2. Child interviewed by child psychiatrist. Interview observed in part by pediatrician and psychologist through one-way mirror. 3. Parents interviewed together by social worker (simultaneous with step 2). 4. Team conference (all members). Family waits. Second working hypothesis developed. Further plan and approach established. Referring outside person may be present. 5. Pediatrician interviews parents and child together and then examines child. One parent may remain during the examination. Other team members observe through mirror and continue formulation work. 6. Father may be interviewed separately by psychiatrist near the end of step 5, or mother may be interviewed separately by social worker. 7. Team conference (all members). Family waits. Diagnostic hypothesis formulated and disposition planned. Referring outside person may be present. 8. Child and parents meet in a group conference with child psychiatrist, social worker, pediatrician, and psychologist to receive a progress report and recommendations. Child also interviewed separately by child psychiatrist, if necessary. 	<p>Calls to family and outside resources in regard to disposition.</p>	<ol style="list-style-type: none"> 1. Individual interviews with family members, if needed. 2. Psychological testing of child, if needed. 3. Child and parents interviewed as a group if further clarification of the problem is recommended.

that the father was not emotionally available to the child. They agreed that Bob was likeable and talked easily, but tended to keep his parents off balance with his erratic behavior. The social worker and the psychiatrist suggested that the mother's frequent, rapidly rising rages might mean that she was seriously emotionally disturbed, thus alerting the other team members to observe during the remainder of the evaluation period how this aspect of the mother's behavior affected the child.

All members of the team had already observed Bob's so-called "restless behavior." The discussion,

which resulted in a more precise description based upon the various team members' observations of the child, led to the impression that the likelihood was minimal that Bob had a stimulus-bound distractibility (implying an organic cause). The observations that Bob's restlessness fluctuated supported the likelihood that it was related to anxiety about specific issues. The team members agreed that the interview with the child revealed that he had fears about animals, bodily damage, and loss of self-control inappropriate for his age. He had shown an ability to relate to people warmly, and his restlessness had decreased



From left to right: John B. Livingstone, M.D., Tikvah Portnoi, M.S., Norman Sherry, M.D., Eliyahu Rosenheim, Ph. D., and Silvio Onesti, Jr., M.D., are all on the staff of the Beth Israel Hospital, Boston, Mass. The first four comprise the multidisciplinary team described in this article. Dr. Livingstone is an assistant in child psychiatry. Mrs. Portnoi is chief psychiatric social worker. Dr. Sherry is head of the well-baby clinic. Dr. Rosenheim is an assistant clinical psychologist. Dr. Onesti is head of the child psychiatry unit.

when the psychiatrist helped him see the unrealistic source of some of his anxiety.

The pediatrician and the psychologist brought their expertise to bear on a discussion of the types of neurological difficulty that might be behind Bob's obvious anxiety and restlessness.

The team decided that the parents ought to be present during the physical examination to observe the physician's careful search for a neurological disorder. The pediatrician's full awareness of the parents' fear that the boy had an organic defect guided him in his subsequent interview with them (step 5). In this interview, the parents revealed that the mother had had an automobile accident while she was pregnant with Bob. While examining the child, and afterward as well, the pediatrician spoke to the mother about the possible relationship between the accident and her own and the boy's anxiety. Assured that the pediatrician had discovered no organic defects during the physical and neurological examination, the mother was very receptive to his opinion that the boy's problem did not result directly from the accident.

The rest of the team observed the pediatrician's encounter with the mother and child through the one-way mirror. After learning about the accident, the child psychiatrist decided to interview the father (step 6). The father told him that Bob's mother had been driving the car when the accident occurred and afterward had expressed anxiety about having perhaps injured the fetus through her "careless driving." The psychiatrist helped the father increase his appreciation of the psychological nature of some of his

wife's (and his own) fears about Bob's condition. The father responded with a more supportive attitude toward his wife.

The next team conference (step 7) followed the pediatric examination. In this conference, the pediatrician reported to the other team members that Bob's mild clumsiness was within normal limits and that the results of his examination did not warrant further neurological investigation. The psychologist said that psychological testing might further establish the basis of Bob's anxiety and give clues to any undetected organic dysfunction that might exist.

While this conference was in progress, the team had an opportunity to observe through the one-way mirror an exchange between the waiting parents. Because the mother revealed an unexpected lessening of her belief that Bob's problems were organically caused, the team decided she could be told directly that day that psychological problems were of major importance in Bob's difficulties and that she could help him if she accepted some guidance about how to deal with him.

The final parent-child group conference included Bob, his parents, the psychiatrist, the social worker, the pediatrician, and the psychologist (step 8).

In this conference, the child psychiatrist led the presentation and discussion of the team's findings. The psychiatrist also advised the mother to stop joking with Bob about his difficulty in distinguishing his nightmares from reality. The psychologist advised the parents to bring Bob back for a psychological test and explained why this would be useful. The pediatrician again stressed that he had not found any evidence of neurological disorder in the child.

During this session, the mother showed evidence of extreme anxiety and therefore the social worker offered to discuss her questions with her in an interview the following week, an offer that the mother accepted. She also agreed to bring Bob back for psychological testing and for another interview with the psychiatrist.

During this second visit, Bob's restlessness noticeably decreased when he became aware that the psychiatrist understood his constant state of fright and wish for help and that his parents now also understood his problems better and would try to help him. The psychological testing showed that Bob was indeed preoccupied with aggressive fantasies with which he was barely coping. The tests gave no evidence of organic dysfunction.

The family came back to the clinic for a third visit during which they had a conference with the child

psychiatrist, social worker, and psychologist. In this conference, the team elaborated on the psychological nature of Bob's problem and recommended that Bob have long-term therapy and that his parents have counseling. The parents did not shop around at other clinics, agreed to follow through with the recommendation, and Bob was put on the treatment waiting list.

At this point, the school guidance counselor and family physician were each given a comprehensive picture of Bob's problems. The guidance counselor, who had been present, agreed to continue working with the child until the psychotherapy could be begun, with the understanding that the team would provide continuing consultation and occasional guidance to the parents.

The team believes that in this case the condensation of the time taken for the evaluation, the multidisciplinary approach, the rapid feedback of findings to the parents and child, and the time taken during the first visit to allay some of the parents' anxiety were the factors that allowed this family to stay with the evaluation and to accept the recommendations, in contrast to their failure to follow through with the other clinic's advice.

Treatment

Our clinic has developed a special interest in the issues that precipitate a child's decreasing capability to function and in the criteria for distinguishing between a crisis of maturation or situation and the beginnings of psychopathology. In this regard, the pediatrician and psychologist have been of special value in providing a backdrop of developmental normality against which psychopathology may be assessed. Thus the team has become able to move quickly from diagnosis to appropriate intervention.

For example, during the single, 3-hour session to evaluate the condition of a child with a sleep disturbance of 10 weeks' duration, precipitated by a baseball accident, the team decided to provide brief psychotherapy to the child and his parents. The decision was based on the team's assessment of the psychological strength of the parents and the child and their mutually supportive relationships. Consequently, the family returned for two visits during which the psychiatrist helped the child see the link between his sleeplessness and the accident as well as the relationship of the fears that were keeping him awake to his own unexpressed wishes for revenge. The social worker clarified the same issues for the parents so that they could help the child verbalize his anxiety

and thereby master his fears. In a joint interview with the child and his parents, the psychiatrist and social worker advised the parents to stop their practice of allowing the child to get into bed with them as they had been doing since the accident. Pointing out that this arrangement only perpetuated his sleeplessness, the team members suggested ways of supporting him during the change back to his own bedroom.

The child soon got over his sleeplessness and returned to his normal activities with his friends, thus indicating that the brief treatment was appropriate. A longer period of counseling this child and his parents might have interfered with the family's healthy coping mechanisms.

Our treatment of a child with symptoms of school phobia also illustrates the usefulness of the multidisciplinary method. During the 3-hour visit of the mother and child at the clinic, the psychiatrist and the pediatrician together helped alleviate the unrealistic anxiety felt by both the mother and the child about the child's physical health. The social worker helped the mother to express enough hostility over other issues to alter her tendency to displace negative feelings onto the child, thus freeing her to allow more separation between them. Almost immediately after the visit, the child psychiatrist transmitted the team's diagnosis and recommendations to the child's teacher and the school nurse, offering them continuing consultation in dealing with the child. This supported them in a united stand in insisting on school attendance.

This method of collaboration and rapid action has proved effective in returning to school not only younger children but also some seriously disturbed older children in regard to whom the team decided that this was a clinically responsible goal.

The team partnership also fills a gap in the diagnosis and continuing management of mixed somatic and psychological problems. An example is provided by the case of an 11-year-old boy with epilepsy and a complex learning problem. His condition had been thoroughly evaluated in several clinics. However, the parents and the child had never been given a coordinated summary of the findings, and their anxiety about specific issues had not been dealt with. In our clinic the diagnosis was confirmed and further refined by the team, the parents were apprised of what was involved, and a plan was established for continuing medical supervision of the boy by our pediatrician, with consultation from the team as a whole.

Thus, in this clinic many kinds of plans for deal-

ing with the problems identified are possible. The careful initial assessment determines the intensity and duration of the clinic's involvement in any specific case. This varies from a single, brief followup contact to continuing contacts over a specified period of time aimed at achieving specific goals. In every case, the particular needs of the child and his family determine which members of the team continue to have direct contact with the family.

As illustrated in the cases cited, the team sometimes provides consultation to community agents already working with the child outside the clinic, such as the child's school guidance counselor, teacher, or pediatrician, and encourages them to attend the evaluation session. When the team refers a child to an outside agency, such as a family service society or a day nursery, it provides continuing consultation to that agency in regard to the child. When a child is referred to the Beth Israel Child Psychiatry Unit for long-term psychotherapy, the team participates in establishing the goals of the therapy and is available for future assessment.

Time records are kept in each case to provide a continuous evaluation of the time expenditure of both the patients and the staff. In regular staff conferences with the head of the Child Psychiatry Unit, the team reviews cases, evaluates the quality of team functioning, and reviews and reformulates, when necessary, the clinic's techniques and objectives. There is a clinical followup study of each case and also a study of opinions and results of the clinic's service, obtained from the patient's parents, the school, and others. In this followup, we seek not only opinions but also objective data for assessing the degree to which our efforts alter a pathological adjustment and foster developmental progress. We are also developing a terminology for describing and comparing the methods used with each family.

Some observations

A team functions most effectively on behalf of its patients when one member—in our clinic, the child psychiatrist—carries the ultimate responsibility for synthesizing all the diagnostic data into a comprehensive understanding of the child in his environment. The difference in our type of collaboration from the usual approach in a child guidance clinic is that while each team member contributes to the

evaluation of the problem according to his special skill, a well-formulated understanding of the child and his parents dictates the specific way in which the skills of each member are combined in dealing with each case. For example, in some cases the family's exclusive orientation toward physical illness makes the pediatrician the most effective person to discuss psychological issues with the child and parents. He does this by stressing pertinent findings of the physical examination and by carefully phrasing his comments to the parents.

We strongly believe that an arbitrary separation of the roles of individual team members is not in the best interests of the child patient. However, we also strongly believe that the special skills of each professional person should be exploited to their fullest advantage.

The conference system provides the team members opportunity for immediate discussion of observations made together and separately in the clinic along with information otherwise obtained. It enables the team to develop a comprehensive understanding of the child and his parents rapidly, and it enables the appropriate team member to work with the child and the parents at a time when they are most receptive to help.

When parents are helped early in their clinic contact to understand some of the major issues contributing to their child's maladjustment, they are more likely to be receptive to counseling in regard to these issues after the evaluation is completed. Also when the clinic quickly informs appropriate outside persons of the findings and recommendations regarding the child, the clinic goals are kept in line with the reasons the child was referred to it and coordinated aftercare is more likely to be achieved.

This type of collaboration also has advantages for the team members as professional persons, for it provides an opportunity for each to learn from the others, thus enhancing the gratification derived from an understanding of one's patients and from an appreciation of one's colleagues.

¹ Gardner, G. E.: The child and the adolescent. In *The psychiatric unit in a general hospital*. (Ralph M. Kaufman, ed.) International Universities Press, New York, N.Y. 1965.

² Lourie, R. S.: The teaching of child psychiatry in pediatrics. *Journal of Child Psychiatry*, July 1962.

³ Benton, A. L.: Some aspects of mental retardation. *American Journal of Orthopsychiatry*, March 1965.

a school
guidance
class

for EMOTIONALLY DISTURBED CHILDREN

WENDY LEHRMAN

As a teacher turned therapeutic teacher over the past decade, I find that my functions have changed in some ways, but that in others they have, surprisingly, remained the same. If the goal of education is to enable the student to understand the laws that govern the conduct of life, then the goal of therapeutic education is no different. But the means of reaching that goal for emotionally disturbed children in a public school setting differ in kind and degree. They must be altered to help such children clarify perceptions that deviate from reality.

The 8-year-olds I teach in a third-grade junior guidance class—one of two at Public School 87 in the Upper West Side of Manhattan—have presented patterns of deviant behavior ranging from extreme withdrawal to extreme acting up. These emotionally disturbed children, who come from many different socioeconomic and ethnic backgrounds in New York City, have IQ's ranging from average to high. Some children have been diagnosed by psychiatrists as having schizophrenia and some as having character disorders. Some are more mildly disturbed than others. For some, we have no clinical diagnosis.

This class is one of 261 junior guidance classes in 110 elementary schools in New York City, with a total attendance of about 3,000 troubled children. Within the several basic designs that have evolved to meet the children's needs, there are numerous mutations. The design for the type of class I teach calls for a full-time "home" teacher plus a "unit" teacher shared with another junior guidance class in the same school. The unit teacher sometimes works together with the home teacher and sometimes teaches the class by himself.

He also is responsible for keeping records. Teachers remain with the same class for 2 years.

In each school the home and unit teachers, a guidance counselor, an administrator, and sometimes a clinical or social work specialist form a therapeutic education team. This team makes the final selection of the children for the junior guidance classes. Regular classroom teachers suggest guidance classes for children who have had persistent problems. Children are also recommended for the classes on the basis of their school records, observation by guidance counselors or school administrators during classroom visits, consultations with parents, and suggestions from mental health clinicians, social workers, psychologists, and psychiatrists.

The therapeutic education team attempts to define and resolve some of the children's difficulties through weekly conferences that develop programs for individual children as well as the class. In addition, teachers meet weekly to develop detailed curricula.

Our task in relation to the emotionally disturbed child is to make his experience—intellectual, physical, social, and emotional—intelligible to the end that his energy is freed for creative, productive activity.

From this point of view, every act of every child has meaning to the teacher of emotionally disturbed children. And clearly the converse is true. Every act of the teacher has meaning to every child. The teacher, then, must create an environment in the classroom that reflects his intention to eliminate inhibiting factors, discourage regressive behavior, and help the children learn how to cope with their problems. He must work within this context in planning and carrying out the arrangement of the classroom, the day's

schedule, appropriate procedures and methods, the lesson content, and his particular style of teaching.

A tall order. I, for one, often fail to fill it—sometimes I fail for personal reasons; sometimes for reasons beyond my control. We face a host of obstacles in working with emotionally disturbed children: too few staff members, meager supplies, lack of space, inadequate health services, few supportive services, and little or no special education for the teacher.

Yet we are attaining our goals with a significant number of children for whom previous schooling had failed. Many of the poorly achieving children reach, or come close to, “grade level” in academic areas during their stay in the junior guidance class. They grow strong, healthy ties to their group, ties which more often than not extend to the school and the community. They develop insight into the logic of their own behavior and learn to select alternatives that are more nearly appropriate to their needs and circumstances. Placements are usually for 2 years, although a child may be in the program for 1 to 6 years, depending on his need. Most of our children eventually go on to regular classes, where they are able to function well. For the few children who cannot, we recommend a transfer to special schools.

Among the shortcomings of our program is a lack of provision for objective evaluation. Nevertheless, I believe some aspects have enabled us to make real strides—establishment of junior guidance classes as part of the total school community, designation of a time in which individual children's needs are met within a fairly loose group setting, carefully designed group experiences, and development of flexible approaches to children whose needs are not always met by planned activities.

In starting each new group, we have had to overcome feelings of alienation, which are intensified in the parents as well as the children upon placement in a junior guidance class. Misgivings about the

placement of children may be relieved when parents get to know a teacher informally through parent-teacher activities in the school or community. I believe it is important for parents to identify us as teachers, not merely as special teachers.

In addition, the parents need to understand the advantages of the special class for their child. The guidance counselor is responsible for explaining the program to parents and working with them. Before the child is admitted to a junior guidance class, the guidance counselor discusses reasons for placement with the parents.

We prefer to accept children of parents who seem capable of long-term cooperation with our efforts. But we do take other children. We feel satisfied that most parents of the children in our class understand and approve of our methods and goals.

Meaning for children

Of greater consequence, even than parental understanding, is the child's understanding of the meaning of his new class. The class *is* startlingly different. The children do feel apprehensive. Any change is more difficult to accept for emotionally disturbed children than for healthier children. The change to a special class may be too burdensome for the children to bear unless the unfamiliar elements are accounted for and put into perspective. For example, the children have not been in a small class before; they have not had two teachers at the same time; nor have they eaten their lunches in their classroom. So immediate efforts must be made to clarify the situation for them.

The first period of the first day of school is devoted to the exploration of these differences. The children are encouraged to say how the classroom differs from their expectations of a third-grade classroom.

“There are blocks and dolls.”

“Why are there two teachers?”

“It looks like a kindergarten.”

The children are then asked what they think blocks and dolls are doing in a third-grade room.

“It's a class for retards.”

“It's a class for bad kids.”

We try to clear up these misconceptions by helping the children investigate the realities of the situation. They soon realize that the group is not remarkable either for retardation or wickedness. They then give other explanations for the dolls and blocks.

“You want us to practice to make real houses.”

“We will learn to take care of babies when we grow up.”



Wendy Lehrman has spent the past 9 years of her 20-year teaching career in public and private elementary schools in New York teaching the emotionally disturbed children in the junior guidance classes she describes in her article. She also conducts inservice courses in the teaching of emotionally disturbed children for teachers and mental

health workers. She is a lecturer at Brooklyn College and New York University, where she earned a master's degree.

We help the children understand the concepts underlying the structure of the class and its use of materials. We explain that the materials are not playthings, but working tools with which to achieve success in such areas as arithmetic, language, science, art, and the expression of feelings—all legitimate goals of education.

Neither on this first day nor at any other time during the year do we deny differences. Instead, we help the children understand that "different" means nothing by itself, but only in relation to another quality or quantity, and that it does not mean "better" or "worse." A small class that uses blocks and dolls is not a "worse" class. It enables the teachers and children to function effectively and suits other needs.

To allay the children's anxiety about the unusual nature of the junior guidance class, the school tries to show to the entire student body those aspects of the special class that parallel the school's regular program. When feasible, the guidance class follows the school's regular procedures. By the second year the children attend assembly programs regularly and they join other classes in music and physical education. There are limits to such activities, of course, and in dealing with special problems we always try to place honesty above conformity.

Some children readily understand the meaning of the class. For example, Carlos, who was placed in the class because of extremely withdrawn behavior, caught on immediately. He was present at our conference when his mother, upset by the gossip of misinformed neighbors, asked that he be removed. She stated that she would not object to having him put back a grade or even two, but that she did not want him in this special class. We assured her that he was very bright, but that in a larger group he had been overwhelmed. "Sure," Carlos chimed in, "I didn't say a single word in the whole second grade."

Challenges

The first daily period serves our unique needs particularly well. We call it a "work period," not a "work and play period." We are not opposed to play on theoretical grounds. Quite the contrary. But as "play" and "work" are code words to many children, we make a distinction for the sake of expediency. We do try, however, as the year goes on to help the children distinguish between "horsing around" and acceptable play.

Low dividers separate parts of the room from each other. There is a block corner, a work bench, a drama

corner (never called a doll corner, for the boys are very active there), an easel, and a work table for various activities—cutting, pasting, mixing papier-maché, and so on—as well as pupil desks.

Procedures have been established to avoid crowding, undue disorder, interference, and other trouble-making situations. As the children arrive in class, they get busy with some work in progress or with something new. The teacher's words, attitudes, and actions clearly indicate that productive activities are an essential part of school. In a junior guidance class, making something beautiful out of a lump of clay is as important as reading, writing, and arithmetic. The children know this and accept such work as a challenge. Producing something gives them great satisfaction.

The challenge is completely individualized. It allows for experimentation, the expression of curiosity, the reinforcement of strengths, and the surmounting of weaknesses. It may be a time for interaction with others or a time to be alone. Each child can take steps entirely at his own speed and in his own way. There are differences in development. Some children experience immediate success; others do not seem to progress at all. For them, any independent effort to control the environment competently can be painfully difficult.

Joe was put in the class as a result of leaden passivity. He spent several weeks huddled at his desk with his coat on, staring at a wall. When he got to the point of rising to watch the other children work, we rejoiced. Occasionally he helped his classmates by steadying wood for them at the work bench. Joe was obviously afraid that dealing actively with his environment would expose his inadequacy. Our task as his teachers was to support him in making small steps toward some interaction with the world. At first we helped him assemble jigsaw puzzles until he was able to do them by himself. We led him to draw and paint by guiding his hand over the paper. Eventually Joe became independently involved in creative activities, using many different kinds of materials.

Other troubled children used materials in an expansive and grandiose manner. Robert cut a "Bat Man" mask out of the dead center of a large bolt of cloth. He started many other ambitious projects, but finished few. Often he wasted a great deal of material. Our task was to help him evaluate his undertakings realistically in relation to his capacity and the materials available. We encouraged Robert to preplan, to measure, to think ahead. He eventually learned to work efficiently as well as creatively.

Such observations offered us invaluable clues to this boy's learning patterns. Robert might have been considered to be expressing hostility through destructive behavior, and, partly, he was. However, we found that his reading style correlated closely with his creative style. For practical purposes, he could not read at all. However, when he was given a simple, well-illustrated story that contained a few familiar key words, he would simulate the act of reading, fabricating a story that had an eerie resemblance to the original.

He obviously went right to the center of things, using his innate intelligence and linguistic gifts, but his directness—combined with his failure to grasp relevant details—impeded his reading. Our task was to acquaint him with the written word and help him discover its relation to the spoken word. After we encouraged him to analyze the material of his own stories, he was able to establish the necessary links.

Joe, a boy I have already mentioned, stared rigidly ahead when he was first given reading material. He would not make up his own stories. We viewed his unresponsiveness as another manifestation of his feeling of vulnerability and his fear of exposure. We made up simple, phonetically based sentences in comic book form, which we read to him. For example:

The rat bit Bat Man.

Bat Man hit the rat.

The rat ran.

His only response—one we recognized as highly significant—was to relax his body and focus his eyes upon the page. We continued to read to him for weeks as he listened passively. Then he began to move his lips with us. Finally he whispered the words.

Ann, a twin girl referred to us because of her low level of achievement, seemed to show evidence of perceptual difficulties. In reading and writing she reversed letters and interchanged initial and final consonants. During the work period, we encouraged her to arrange cutouts, jigsaw puzzles, and similar materials that could help her overcome reversal problems. She preferred the drama corner, where she would act out scenes with a doll she called by the name of her domineering twin sister, who was in a regular class. Ann scolded and beat the doll unmercifully. When a reading period followed these dramas, Ann showed no signs of perceptual difficulty. Although she did not receive special training, in a short time Ann was reading at a level a half grade higher than when she came to us, and she no longer had reversal problems.

Group lessons are important. I think we have no legitimate function as a therapeutic education program based in a school unless we use the group as one of our major rehabilitative tools. In academic areas, we design our lessons so that the challenges presented can be met on many levels by children with different abilities and backgrounds.

In a language lesson, for example, reading material is placed where it is visible to all members of the class. The teacher reads to the children, who respond by making discoveries. A nonreader may discover that "car," "can," and "Catherine" begin with the same letter. The class explores the implications of this discovery. A child who reads very well may discover that "automat" has a root in common with "automobile" and "automation." Again the entire class discusses the discovery. Each child gets a chance to express himself. All responses are given serious consideration.

At times we form small groups, based on common needs that have become apparent during the class lesson—not on overall reading ability. Children's individual needs often cross grade levels. For example, a child may read, "Deed man tell no tales." Although he may be at his proper grade level in reading, he needs exercise in the use of context.

Class disturbances

Thus, we have created an environment that fosters independent discovery and productive response at each child's pace and in his own way. But in doing so we have not resolved all the problems of a junior guidance class. Some children find our very reasonableness shattering. They are unable to accept alternative solutions to problems. Any suggestion that they change their ways is perceived as a threat to their systems of defense, and their behavior becomes increasingly rigid.

For example, one day during storytime, Willie noticed a pretty stone that belonged to another child and tried to snatch it away. When I did not permit him to take it, Willie threw a chair across the room. The other children and I expressed our concern for Willie but insisted that the other child be allowed to keep his stone.

Although the children know it helps to remain seated during a furor, one classmate got up and went over to Willie, holding out his hand. "Come on Willie," he said, "we want to hear the story. You can have my stone." But Willie refused the offer and continued his tantrum until the class was dismissed.

As the children left, one asked, "Why'd you have to do that?"

Willie replied, "Do you think I like to act that way?"

Such insight is tremendously useful to the troubled child. But increased self-knowledge often seems threatening to the child unless he knows of safe alternative ways of dealing with his feelings of inadequacy. The teacher's job is to help the child become aware of those alternatives.

Whenever possible, we continue to identify the confusing elements of a disturbance in the context of the group.

For example, the class was disrupted every day—often several times a day—by Frank, a child who could not accept the established alternatives of participating in an arithmetic lesson or occupying himself at some independent activity. At the onset of the mathematics period, he regularly sought to distract the class by some engaging antic, such as blowing spit balls through a straw or flipping monster cards about the room. The children have learned to ignore such exhibitions but to offer help to Frank in resolving the problems that lead to such inappropriate horseplay in the classroom. One day the children discussed the events that led to Frank's disruptions.

"It always happens at the math lesson."

"He hates math."

"He's dumb in math."

"So, he could go alone."

"Why won't you work at something alone?" I asked Frank.

"I don't want to go to the back of the room," he answered.

"He don't want to be alone."

Finally, one child asked me, "Could someone go with him and help him?"

Thus, Frank's problem was conceptualized. He felt inadequate in mathematics. The established alternative to studying mathematics with the class—doing something else quietly alone—was unacceptable to him. But the class discussion had opened a new alternative to resolve Frank's conflict in a constructive manner. We assigned a child as his helper. When the mathematics lesson began, Frank and his helper occupied themselves quietly at the back of the room in productive pursuits related to mathematics, and this became the pattern from that day on.

Some of the problems that the children face are beyond our reach. Although we are well aware that, as Bruno Bettelheim has pointed out, love is not enough,¹ we have found that it can be fairly power-

ful. Tommy was one who taught us this. Tommy, who for 6 years had lived with a severely alcoholic stepfather and an increasingly alcoholic mother, was placed with us after being suspended from school. He spent the first few months in class in apparent peace when engaged in solitary, nonacademic tasks. But he became violent when anyone encroached on his privacy or made any demands on him.

Tommy's tantrums were entirely self-destructive. He would throw himself down, bang his head forcefully on the floor, twisting, screaming, and crying all the while. This happened many times a day—when he was asked to join a lesson, to sit down at lunch, or to share his blocks, for example.

We continued to reach out to Tommy in spite of his rebuffs. One day he said, "You're not doing nothing. Just get my father to stop beating me and my mother."


We tried to achieve this by working through a social agency. Although we did not succeed, Tommy knew of our efforts and his behavior changed radically. Through our attempts to help, we had made it clear to him that he was important to us and loved by us. He was worth loving.

IN SUMMARY, we proceed on the theory that the basic principles of education apply as well to the teaching of emotionally disturbed children as to the teaching of normal children. The therapeutic educator has a broad responsibility to create a rational program for the physical, mental, social, and emotional development of each child. We do not conceive of the task of therapeutic teachers merely in terms of training troubled children for modification of behavior. Nor do we deal directly in techniques developed uniquely for psychotherapy.

We have made use of a regular school as an appropriate setting for the rehabilitation of the troubled child. Such a child, with disabling patterns of defense, is limited by erroneous assumptions that belabored his ability to cope with reality. While the child is learning to develop and maintain constructive ties with crucial elements of his society, he is also receiving help from a therapeutic team. We try to provide a classroom environment that offers explicit opportunities to each child to make his own lawful discoveries about the world and to develop the skills he needs to utilize, organize, expand, and transform such knowledge.

¹ Bettelheim, Bruno: Love is not enough: the treatment of emotionally disturbed children. The Macmillan Co. (Collier), New York, N.Y. 1950.

combining



SOCIAL CASEWORK and GROUP WORK METHODS

in a CHILDREN'S HOSPITAL

KATHERINE L. HAGBERG

● A few years ago, the social services secretary of a children's hospital, through a typographical error, called efforts to combine the social work methods of group work and casework a "bombination of methods." That indeed is what the combination proved to be. When a social group worker joined the staff of La Rabida Jackson Park Sanitarium in Chicago in 1962, his impact on the five caseworkers was a little like the delayed explosion of a time bomb. Standoffish at first, the caseworkers, who were used to working only with individual children and their parents, eventually were enthusiastically working with groups of children as well.

Many factors contributed to this development,

among them the hospital setting, the children themselves, the freedom allowed the hospital staff to experiment with new approaches in delivering their services, and the enthusiasm of the group worker in demonstrating what could be done for hospitalized children through the group work method.

With a name derived from a Moorish word meaning "outpost on the frontier," La Rabida is a voluntary hospital for children with chronic diseases. Patients range from toddlers to 19-year-olds and come from many socioeconomic and ethnic backgrounds. With such conditions as rheumatic fever, rheumatoid arthritis, other diseases of the connective tissues, nephritis, nephrosis, ulcerative colitis, bronchial asthma, and other allergic diseases, they usually stay in the hospital for 3 or 4 months.

The hospital has a unit for teenagers with 32 beds and its own lounge, and two units for younger children with 35 beds each and a common playroom. In addition, a large room serves as a center for group activities. Most of the patients' rooms contain four beds. A few are single rooms.

The hospital staff makes a continuous effort to meet the patients' medical and emotional needs and to create a climate conducive to recovery. In addition to medical, dental, and nursing care, the hospital services include clinical psychology, occupational therapy, physical therapy, schooling, and recreation. Because of the social and emotional problems that arise from chronic diseases, every child is assigned a caseworker who sees him and his parents on admission, takes a social history, and provides casework service in the hospital and after discharge as needed. Each caseworker is assigned to a specific hospital unit.

The arrangement of the hospital rooms contributes to the spontaneous formation of friendship groups. Social workers at La Rabida have always tried to use the "group spirit" that develops naturally within the rooms to help the patients. For example, one day a social worker entered a room to find three beds rolled up in back and the three little girls "sliding down the hill." The children explained that they were "helping Anita 'cause she's got rheumatoid arthritis and needs exercise." This group sustained Anita in her efforts to walk by helping her overcome some of her fear.

As in this instance, the caseworkers sometimes build on their patients' relationships with each other in helping individual children cope with their problems. A social worker and a physician helped parent groups understand the normal needs of children with chronic diseases, an effort that influenced the formation

tion of an auxiliary called the Parents and Friends of La Rabida.

The hospital began its planned group work program in 1962 when a full-time professional social group worker was assigned to the hospital by the Heart Disease Control Program of the U.S. Public Health Service. It was agreed that he would develop a group work program and the hospital's social work director would, in turn, teach him the casework method. At that time the hospital also obtained the services of a group work consultant, a professor of social group work at the University of Chicago. It was decided to begin with the teenagers.

The group worker used three techniques in developing the teen program: working informally with the teenage boys on a one-to-one basis and in small groups, working with organized groups, and working as a member of the total hospital team. He defined the purposes of group work at La Rabida as follows: (1) to help the teenagers cope with the normal stresses of adolescence as well as with the stresses of hospitalization; (2) to develop tools to help them cope with the problems of chronic disease; (3) to enhance their social functioning; (4) to develop and work within the emotional climate, or "norm," of the teen unit; and (5) to help the youngsters understand that they were not completely controlled by the environment, but could constructively change parts of it.

As the program developed, the group worker organized a teen council elected by the patients, on which the head nurse and the group worker also served. Eventually the staff formed a Teen Ward Interdisciplinary Committee.

The group worker was given responsibility for directing group work with all adolescent boys, taking social histories on their admission to the hospital and carrying through with individual casework services for these boys and their parents. Social caseworkers continued to work on a one-to-one basis with the teenage girls and some of the more disturbed teenage boys.

The caseworkers welcomed the group worker when he arrived, but they were slow to accept his method. When responsibility for the same child was shared by the group worker and a social caseworker, problems developed about communication, overidentification with the child, possessiveness, and hesitancy in becoming involved in meeting needs of another worker's patient. Time-consuming joint conferences were held to resolve such problems; mutual respect evolved only after heated staff discussions.

At social work staff meetings similarities and dif-

ferences in casework and group work methods were discussed. The social workers found that the basic methods differed only in the number of persons involved at one time, the number and variety of roles that the worker assumed in a group session, and—occasionally—the focus and purpose of the group. When the staff examined excerpts from records of the caseworkers and the group worker, it had trouble deciding whether to classify the methods as casework or group work.

Combining the methods

A pilot study made at La Rabida in 1963¹ had shown that anxiety about hospitalization among children with rheumatic fever decreased after a stay in the hospital. Children who met in groups showed less anxiety at the end of the study than those not in groups selected as controls. Those who met in a group with a pediatrician they already knew showed the least anxiety of all. The results of this study added impetus to forming patient groups and to assigning social workers to provide both casework and group work service to the same patients.

By 1964, the caseworker assigned to work individually with the teenage girls agreed to work with the teenage girls' group. A year later, three other caseworkers decided to use the combination of casework and group work methods in working with their patients.

The major purpose in combining methods was to enable social workers to give needed intensive casework to more children. Initial goals were similar to those described by the group worker, although the caseworkers placed greater emphasis on the use of the group to help individual children.

Gradually the caseworkers noted other benefits from group work and evolved the following goals: (1) to alleviate the children's anxiety and pent-up anger over illness and hospitalization; (2) to provide an opportunity for patients to master the trauma of their illnesses; (3) to give hospitalized children a constructive experience in socialization as well as to protect them from feelings of separation and isolation; (4) to help prevent psychological or emotional damage; and (5) to facilitate the caseworker's efforts to help children individually with their problems.

In all, La Rabida has had six activity groups for patients: teenage boys, teenage girls, two groups of younger girls, and two groups of younger boys. All activity groups had therapeutic overtones. Each

group met weekly but members were not required to attend. Membership, which was open to all patients in the specified age range, changed frequently with admissions and discharges.

Group activities

What activities to use in the group sessions posed some problems for the caseworkers, as they were not trained to work in crafts and games. But with the help of the group worker and the occupational therapist, a variety of projects were developed.

For example, checkers and chess tournaments provided an outlet for the competitiveness and aggression of the 10- to 12-year-old boys who could not participate in active sports. Another group spent several weeks building a huge papier-mâché monsterland that reflected their anger in being hospitalized. When feelings reached a high pitch, they often sang the "La Rabida Jail Song."

The boys wrote and presented a play called "A Day at La Rabida." When they gave a performance for their parents, they ad-libbed freely—especially about the hated rectal temperature taking. The leader of the ad-libbing was a child who had been very good and very quiet at home. At the height of the action he shouted, "Boy, I like talking back!" His mother, who had earlier refused casework service for herself, telephoned the social worker the following morning to make an appointment for treatment.

Group meetings helped the little girls express their feelings about being in the hospital. The following excerpts were recorded by a student who helped in the group meetings:

The social worker began the meeting by teaching the song "Polly Had A Dolly." The girls acted out the song as they sang it. It's about a dolly who got sick and the doctor sent her to bed.

We went around the circle and each girl told what sickness her doll had. Most said rheumatic fever. Mary, Shirley, Carol, and Lenora didn't know. Laura pulled her talking doll's string under the table and mouthed the words. She whispered to Dimetra to mouth the words when it was her turn and she did. Nilsa, who had been hospitalized for some months, said her doll had to stay in bed for 5 years! Nilsa led the "La Rabida Jail Song."

The little girls in this group also turned to drama. They spent several meetings working out plans for a puppet show, making puppets, and writing a script. In these activities, they expressed their own feelings about being sick. Their reactions, however, were less violent than those expressed by the boys.

The social worker suggested that the girls divide the show into three acts—the first about when they entered the hospital, the second, about their time in the hospital, and the third, about going home.

Linda answered questions about how scared she was when she first came to the hospital, but she did not practice with her puppet.

Clara, Lisa, and Laura practiced about 15 minutes. The puppet patient (Lisa) got sick and the puppet doctor (Clara) yelled, "Bring her a bucket!" When the doctor gave shots or blood tests, he was very rough with his patients. The papier-mâché heads banged together frequently.

Rachel came in with her puppet and said, "I don't want to do anything." Lisa said, "Just hold the mother puppet and I'll talk." Rachel held the puppet and seemed to enjoy it. After the mother arrived on the stage, Lisa announced with a nasal twang, "Visiting hours are over. Visiting hours are over." Then she added, "The poor mother visitor didn't ever get to stay long."

The enthusiasm of the girls increased when they presented the play before the younger girls. The student helper described the event:

The younger girls were all seated in rows in front of the stage waiting for the puppet show to begin. As the curtain went up after the social worker's introduction, the puppet patient (Lisa) entered La Rabida and met the puppet nurse (Laura). They read the script prepared beforehand. The children in the audience laughed when the patient was told she had a rheumatic heart and needed bed rest. There was a lot of kissing between mother and daughter during the short visiting hour, which also brought laughter. After the first show, the puppeteers put on a much more violent version that they ad-libbed. The audience obviously enjoyed the violence.

This example not only illustrates how children relieved their feelings through group play but also how such play freed them to help each other. Group sessions also helped social workers speed up the progress they were making with individual children. For example, Linda—an emotionally deprived child—had been frightened, withdrawn, and unreachable. After she took part in the group's puppet show, she was able to talk about her problems in individual sessions with her social worker. She could relate to other adults. Her personality blossomed.

Teenage groups

The teenage groups conduct more sophisticated projects. The longer experience in group work with teenagers has resulted in the establishment of some ground rules. When the teenage patients plan money-raising activities, they appoint committees to meet with representatives of the hospital administration in regard to money and supplies, with the doctor to

obtain approval of the planned activities, and with the dietitian in regard to food. They work out problems concerning the rules through the teen council. Group officers handle the money, but the members—as a group—decide what they want to do with their funds.

The group discussions, large and small, that take place when the patients undertake a project provide relief from the boredom of long-term hospitalization and help in handling fears of illness. Of greater value, however, are the lessons that the patients learn as they assume responsibility and develop respect for rules, for authority, and—most important—for themselves. Pinky, an emotionally deprived and angry teenage girl, told the social worker, “What I learned at La Rabida is I don’t have to hold my head down when I talk to people!”

In a planning session for a Christmas bazaar, one boy told the members of the group not to bother putting their best efforts into producing items for sale because “People feel sorry for us cripples and will buy anything we make.” The teenagers discussed this idea thoroughly. They voiced their worries over self-image, fear of being “different,” and fear of death or permanent disability. They decided they were not “selling pity.” The group agreed to encourage members to maintain high standards for their handiwork.

With the money made from the bazaar, this group bought a giant tricycle for physical therapy. Its members shared in the sense of accomplishment when one of them—a boy with severe rheumatoid arthritis—worked until he was able to mount the tricycle and ride it triumphantly down the hall.

A carnival

One of the most ambitious projects was the La Rabida Teen Carnival. The teenage boys, teenage girls, and staff members—nurses, residents, teachers, the occupational therapist, the dietitian, the group worker, and the caseworker—worked together to make the carnival a success.

The carnival was held during visiting hours so parents could attend. Decorated stands produced a gay atmosphere. Patients in wheelchairs sold tickets and played phonograph records. Other teenagers operated a bowling ball roll, a fish pond, miniature car races, and a paint-spinner machine. Prizes made by the teenagers were awarded frequently. Girls made and sold candy, popcorn, and punch.

The teen group decided to use the profits from the carnival to buy a hi-fi for the newly completed teen

lounge. It selected one that did not match the other furniture, much to the distress of the lounge’s interior decorator. The hospital staff supported the patients and the hi-fi remained. This demonstration gave the teenagers both a sense of their own worth and the satisfaction of knowing that they had some control over their environment.

Collaborative efforts, such as the carnival and the bazaar, improve staff relations and minimize the problems of communication for the social workers. The use of the two methods of social work adds value and depth to collaborative efforts on behalf of patients.

Other staff members, who frequently do not understand what goes on in a one-to-one casework session, can see social workers in action in a group. All can share the social workers’ enthusiasm when a withdrawn child stamps her foot and shouts that she “will not wear braces” or when the child with a behavior problem is elected custodian of the comic books and handles the job well.

Treatment values

Minnie Harlow has called the hospital a “living laboratory,”² an apt description for the groups at La Rabida. During group sessions, the social worker sees things happening; he does not have to rely on reports from other staff members. As one social worker has assessed the group sessions, “Diagnosis is the *great* value. As the boys work on some project—building something, planning activities—things happen among them that grow out of patterns you know occur in their rooms Sometimes you can work with [the feeling a boy reveals] on the spot, sometimes not with 15 kids around, but you can pick it up later.”³

In the security of the group, children often make unguarded responses in words or actions that might take many individual therapy sessions to elicit.

For example, a group discussion helped 9-year-old Sandy break through the shell into which she had withdrawn after the death of her father. In one-to-one sessions, she had been unable to mourn his loss or even to mention him. One day in a group meeting the other girls bragged about past vacations. Sandy said, “Last summer my father took us to see the Indians at the Dells.” Then she clapped her hands over her mouth and looked furtively around to see if anyone had heard her. With a little encouragement, Sandy talked about the boat ride and Indian dances, but she did not mention her father again to

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the group. Later she talked volubly of him to the social worker.

The many kinds of nonverbal communication in group interaction speed the social worker's understanding of each child. The social worker has an opportunity to test a child's concepts of reality, and to observe the way a child socializes with other children. By comparing his own observations with the parents' reports, the social worker often reaches greater understanding of the quality of the parent-child relationship.

Meeting with a group of children, most of whom have problems, makes heavy demands on the social worker. Listening with the "third ear" is much more complicated in a group than with one child. The social worker must relate to and show his empathy for several children at the same time. Often such a public demonstration of understanding and respect for the individual child means more to him than the understanding shown the child when he is alone with the social worker.

As in casework, study, diagnosis, and treatment are interwoven in group work. It is difficult to draw a line where one ends and the other begins. The La Rabida caseworkers, who were amateurs in the use of the group work method, were intrigued when they found that the group experience made it easier for some patients to learn to trust them. For example, a 10-year-old boy who had always remained uninvolved in individual sessions with the social worker participated in the group activities enthusiastically, responding to the pull of his friends. Soon he began to come to the social worker with ideas. Once this child learned to trust the social worker, he began talking out and enacting his feelings through play in individual sessions.

In a group session, the social worker observes the patterns of interaction that he once only heard about

second hand. Often after a meeting when feelings are still high, the social worker can find out just what is bothering a child. Sometimes the child reveals a problem while the group action is going on. The children themselves are expert in confronting each other and the social worker has to be alert to scapegoating. With sensitive intervention, however, he can guide the children into finding ways to cope with each other. The clown learns to relax and yield the spotlight; the coward, to stand up for his rights; the bully, to develop empathy for his victims; the troublemaker, to discuss his problems openly instead of provoking others to act out his aggressions.

Groups are often amazingly perceptive to the individual needs of their members. They may move the meetings to the room of a child on strict bed rest. They are sensitive to each other's unhappy moods and do not hesitate to explain to the social worker and the group as a whole that "Johnny's doctor didn't give him activity" or "his mother didn't come today." They understand from experience what such a disappointment means.

Problems of relationship

A problem does arise, however, in how to treat a disturbed child who wants the worker to himself both in one-to-one sessions and in group sessions. One boy, for example, had a tantrum because he noticed that a truck in the social worker's office had been moved since his last visit. He yelled, "Some other kid's been down here!" I have come to believe that children in a hospital must learn to share the attention of the social worker as a simple matter of necessity.

No child ever really has a social worker all to himself. The combination of group and individual treatment gives the social worker a chance to help a child learn to realize that life in a hospital—anywhere—demands a certain amount of sharing. Nevertheless, controlling a group as a possessive child giggles, dances, and fights out his point of view can be arduous for the social worker.

Responding to such behavior in a way that meets the needs of the child requires self-awareness, sensitivity, and creativity from the social worker. He must shift readily from one demanding role to the next—observing, confronting, leading, helping other to lead. Sometimes he "loses his cool" and makes mistakes. Most mistakes can be overcome when the group and the social worker have achieved a warm, trusting relationship. But one mistake—that of

breach of confidence—can rarely be repaired. A child who feels betrayed cannot forgive and forget.

For the child with chorea, the group can be used by the social worker for a kind of environmental manipulation. Explaining the physical reasons for his flopping uncontrollably, spilling food, and giggling or crying hysterically relieves the child of the idea that he is "nutty" and relieves the group of "scary" feelings.

The teen unit might have been severely disturbed by a boy who had a kidney disease if the opportunity for discussion had not provided a safety valve. The group discussed the hospital's new dialysis program and the social worker brought a doctor to explain operations of the kidney machine named "Hercules." Understanding the process helped the boy and the other adolescents control their fears.

Parent's groups

Group discussions were also found to be of value for parents. Three caseworkers experimented with parents' groups, inviting parents of the children in their caseloads to meetings to talk over whatever might be bothering them about their hospitalized children, their own reactions to illness and separation from the child, and the difficulties of balancing the sick child's needs with those of their other children at home.

The most successful group of parents was the one composed of five couples who had been in the habit of eating together in the cafeteria each evening. The members responded eagerly to the group and moved rapidly from discussing their children's hospitalization to discussing parent-child relationships. These parents could easily have moved into deeper group therapy, but the sessions ended when the children were discharged from the hospital. Followup casework service was provided parents still in need of help.

Another group, composed of eight to ten anxious parents whose children had rheumatoid arthritis, had resisted family therapy. After attending the parent group sessions, several of the members eventually asked for individual help from the caseworker. The "safety in numbers" the parents felt in the group, the sharing of a common concern about the crippling nature of the disease, and the confrontation that occurred over some parents' tendency to "smothering" overprotection of their sick children helped these defensive parents see their need for therapy. Some

fathers in the group spoke of how hard it was for them to see their sons becoming helpless. Some couples voiced their disagreement over how to handle their sick child; usually the mothers babied the child while the fathers stressed bravery in facing illness.

Perhaps as important as anything else, these parents laughed together about their own behavior, such as the habit of bolting down suppers to get to the hospital during visiting hours. A major value of the group experience was the relief that it brought to the parents from the isolation caused by their anxiety and feelings of guilt.

EFFORTS TO COMBINE the group work and casework methods in helping children and their parents are comparatively new. Evaluative study is needed to find out if the combination of methods produces more lasting values for the child and his family than either method alone. The timing of group or individual therapy, the selection of patients, and various ways of combining the two methods need to be tested through research.

Not every caseworker can tolerate the demands of dealing with his patients in a group as well as individually. However, those who learned to combine the methods at La Rabida seem thereby to be giving better service to more patients without added cost in time and money. They have accomplished giant leaps in getting to know the children and their parents and in developing a relationship of mutual trust with them. The salutary effect on parents and children has been obvious. The most important benefits to the hospital from the use of the combination of social work methods are improved collaboration with other professional staff members and a greater emphasis and interest among the staff in creating a healthy emotional climate. If these gains prove to be lasting, these social workers' efforts to learn new ways of providing service will certainly have been worthwhile.

¹ Ric, H. E.; Boverman, H.; Ozoa, N.; Grossman, B. J.: Tutoring and ventilation: a pilot study of reactions of hospitalized children. *Clinical Pediatrics*, October 1964.

² Harlow, M.: A system of groups in the hospital community dealing with the social functioning of the patient population. Unpublished paper presented at the Carl Menninger Memorial Hospital, Topeka, Kans., Feb. 7, 1967.

³ Moore, Judith M., as quoted in Hagberg, Katherine L.: Report of an experience in combining the use of the two methods of social work in a hospital setting. Proceedings of Second Conference for Social Workers in the Health Field, The Montefiore Hospital Association of Western Pennsylvania, Pittsburgh, Pa., Aug. 28-30, 1966.

a correctional school
aims at rehabilitation by . . .

WORKING with FAMILIES of DELINQUENT BOYS

CARLE F. O'NEIL

● Thoughtful people have been saying for years that when a boy gets into trouble with the law the chances are that his whole family has had a lot to do with it. Nevertheless, young people in correctional institutions too often are treated as though they were "independent agents" who got into trouble on their own and must be straightened out before being sent back home, where they will again be on their own to make it if they can. What is the point of the training school's social histories and clinical conferences, specialized tutoring, vocational training, and counseling if a boy is eventually sent back to the same family mess that helped to produce his delinquency?

When we at the Iowa Training School for Boys started asking ourselves that question several years ago, we decided that, although we did not know much about family therapy, we ought to be figuring out ways of involving the whole family in a boy's train-

ing school experience. Since then we have learned that more families than our present staff could handle would become involved if we would only try to help them to do so. And we have learned some things about how to try.

The Iowa Training School for Boys at Eldora with a capacity of 300, receives delinquent boys between the ages of 12 and 18 committed by a juvenile court. They come from all sections of the State and all income groups, although most are from families of lower socioeconomic status. Their offenses range from truancy and incorrigibility to murder. Many of the boys committed to the school have been recognized as "troubled" or "troublesome" by schools, the police, and others for some time. Most of them have been on probation. But rarely has anyone worked with the boys' parents or other members of their families at any time. This is understandable in view of (1) the lack of community resources to provide the families with the help they need; (2) the lack of "motivation" on the part of the families to seek help for the boys' behavioral problems; and (3) the lack of techniques and motivation on the part of professional persons in the community to meet the needs of these families.

Most of the parents, because of personal uncertainties and communication difficulties, have been unable to seek out help or respond to such meager efforts as may have been made in their direction. When their boy is being taken away from them, they are likely to feel attacked and persecuted themselves. Overly protective and defensive, they present what might be called an "inapproachable fortress syndrome" to harrassed officials, thus perpetuating a cycle of mutual hostility. As a result the officials tend to think of the boys' parents as "hard to reach" regardless of the parents' social or economic circumstances.

Parental attitudes

For several years before inaugurating a special family program, we had been requesting the parents of the boys sent to us to come to the school for an interview within 2 weeks of their boy's commitment. Over the years about 80 percent of the parents accepted these invitations. From our contacts with these parents, we became aware of a number of characteristic responses that parents tended to make to the crisis of a boy's institutionalization:

1. Strong identification with the boy's feeling about being deprived of his freedom.

2. A sense of guilt about the boy's confinement in the institution.

3. Intense anger at the "authorities," expressed through blame and criticism.

4. Discomfort at real or imagined criticism of themselves being made by people in the community or other members of their family.

5. A dim sense of failure in their intrafamily relationships.

6. Belated realization that "something was wrong" and that some kind of help from somewhere was needed.

7. A sense of helplessness.

There were always a few parents who completely and finally rejected the child and all of those dealing officially with him.

Many of the parents have stereotyped ideas about training schools that do not accurately apply to our school. The campus with its vast lawns and many trees, but no fences or walls, would perhaps do justice to a small private college. The school provides a tightly organized program and firm guidelines for behavior in a relaxed atmosphere. While group activities are always supervised by staff members, most of the boys are permitted to move about the grounds to their legitimate activities on their own recognizance. The program is aimed at developing social skills and responsibility, internal control, and a commitment to socially acceptable values.

The training school has no legal means of forcing members of the boys' families to come to the campus or to cooperate with the staff. Were such means available, we would regard them as inimical to our purpose. Therefore, the families must be invited to come and we must seek their voluntary cooperation. One of our primary goals in dealing with parents is to help them realize as quickly as possible that we are not here because we hate delinquent boys or their families, but, rather, that we are concerned about them.

Reaching out

When in 1965 we decided to make an effort to get whole families to work with us in their boys' behalf, we had to face the question of which families. Because we knew we had much to learn, we decided to begin with families presenting differing characteristics in an effort to learn about the problems of treatment as

well as about the families' problems. We made our selections on the basis of social histories received from the juvenile court or from our interviews with the parents, or both. In retrospect we find that our selections could be grouped in three broad classifications:

1. Families of boys whose disorders we did not understand. In these cases every therapeutic endeavor that had thus far been tried in behalf of the boy had failed. Our selection in these instances was made on a desperate "What have we got to lose?" basis.

2. Extremely hostile families presenting a complex, confusing picture of their intrafamily relationships—the largest group in our selection.

3. Families in which we saw areas of strength that might be drawn on in problem resolution. This group included the parents who were strong enough to be inquiring, "Where have we failed?" or who were expressing feelings of guilt. Such evidence of strength does not mean that these parents did not resist change.

Since the parents of our boys are so often mistrustful and hostile, we carefully avoid any suggestion that would imply that we are proposing therapy for them. Rather, we ask them to bring the entire family to meet with us and the committed boy to discuss his presence at the training school, what might have led to the behavior that resulted in his commitment, and what we might do together to help him resolve his difficulties so that he can eventually reside in the community more successfully than in the past.

At first we were unsure of ourselves and how we might meet the challenges we knew the families would present. Therefore, we chose to work in staff teams usually consisting of one or more social workers or psychologists, the boy's houseparent or teacher, and often somebody from his home community such as a clergyman or the parole officer assigned to the area. In such a team, we felt we could learn from one another more readily and could be mutually supportive in weathering the sometimes violent emotional storms that we were sure to encounter.

We have followed rather closely the Multiple Impact Therapy¹ model, scheduling families for 2-day sessions on campus or, in a few instances, in the family's home community. Occasionally, we schedule some families for a series of 2-hour sessions over a period of time and in these sessions we also use the team approach. The type of scheduling is generally

determined by how frequently the family can, or will, come to the campus. Families that live far away or whose members have trouble getting time off from work are scheduled for 2 full days on the campus; those that live closer and can get away fairly easily are scheduled for periodic 2- or 3-hour sessions held at weekly or greater intervals.

When a family comes on campus for 2 days, the staff team usually meets with all the members together, including the committed boy, for four 2-hour sessions. Between sessions the team members meet privately to exchange observations, to plan treatment strategy, and to agree on specific objectives. If the family agrees, we record on tape pictures and sounds of the family interaction during the sessions. Selected portions of these tapes are played back to the family to help the members see how they carry out their specific roles in the family and glimpse patterns of their own behavior of which they were unaware. When tapes are not made, this type of self-observation is achieved by having a member of the family observe the family interaction through a one-way mirror while one of the therapists or another member of the family substitutes for him in the discussion, playing the role as the observer would.

For example, one mother, who clearly wanted to do well by her family, received a startling new awareness of herself from sound tapes. On the second day of our meetings, we played back rather extensive portions of the previous day's sessions. The "discussions" had been hardly more than a monologue by the mother. After listening to her own voice for a half hour, she turned off the recorder and, visibly shaken, said, "I never *dreamed* that I talked so much. Nobody else has a chance to say a word!" To which her son responded in a matter-of-fact way, "Yeah, you talk too much and Daddy don't say nothing." The husband simply said, "That's why I drink a six pack of beer every night."

While some persons may regard the practice of having the entire family discuss the boy together as likely to prolong the boy's status as the family scapegoat, we follow it as a means of meeting the family members where they psychologically are at the moment, accepting them at that point, and then observing their patterns of interrelationship. Gradually the members of the family reveal their feelings of hurt, loneliness, and dependency, as well as the impairment in their patterns of communication. Then we start responding to these feelings and difficulties and in doing so help reduce their use of the boy as a scapegoat.

In one case in which the family consisted of just the father, the mother, and the committed boy, it soon became apparent that the father was very angry with the boy, of whom he spoke critically and derisively at length. One therapist then spent several hours alone with the father, leading him to speak more of himself, his own feelings of worthlessness, and his insecurity in a job depending on a political appointment. Subsequently this father, having found acceptance and understanding, seemed to feel better about himself and was able to show some real warmth toward his boy instead of angry fault-finding.

Intromittive principles

This first reaching-out phase of our work differs, at least in degree and duration, from those methods of family practice in which the patients seek out treatment on their own initiative. We call the approach "intromittive," from the word "intromit," which, according to Webster, means "to send or put in."

Our basic intromittive principles are:

1. The "reaching out" to involve the family must be genuine, supportive, nonjudgmental, and non-punitive.
2. The family members must be made to feel that they are responsible partners of the staff team and are working on behalf of the boy.
3. Trust and hope must be patiently nurtured, especially in the early sessions with the family.
4. Labeling sessions as "therapy" must be carefully avoided, for members of the family may regard unrequested therapy as an assault upon themselves.
5. Meeting hours must be arranged for the family's convenience. This means that sessions are often held at night or on weekends.
6. *Genuine* hospitality must be extended to the families.

We make comfortable apartments available to them, offer them meals on campus, have coffee or cold drinks available on their arrival and from time to time throughout their stay. Their domestic pets are welcome.

If the family has no means of transportation, we provide it. For example, a man telephoned the training school at the hour he and his family had an appointment at the school. He reported that they had

had a blowout on a back road about 20 miles from the school. Since he had no spare tire, he said he doubted that they could come at all. It became apparent that he might have trouble getting the tire repaired. The three staff members who were scheduled to participate as a team in the discussion went out to meet the family and found the parents, seven of their children, and an 8-week-old puppy happy to see them. Our 9-passenger station wagon was just able to hold the group plus the damaged wheel, but everybody made it back to town where the tire was left for replacement. Most important, the team members were dirty and sweaty from the trip, just like the members of the family. The team had truly met these people "where they were" and had demonstrated its concern. Intramittive therapy had begun when the team stopped at the disabled car.

Members of the families we see are rarely introspective, but they are frequently very perceptive and sensitive. To reach them effectively requires complete integrity. In joining our team discussions about the boy, they are venturing into the unknown. We try at all times to remember that they are our guests. (When we find ourselves slipping in our hospitality or privately poking fun at some characteristic of a family, we stop short and examine our own attitudes. Generally self-righteousness or rejection has crept in.) In genuine hospitality, nonverbal communication is of the greatest importance. Such hospitality begets positive response because it is the essence of humanity.

The therapeutic phase

As trust is established, our emphasis shifts from the reaching-out role to therapeutic and educative roles. We have three diagnostic and treatment goals:

1. To become aware of the family "system," so that specific areas of dysfunction will become clear to us.
2. To help the members of the family see these areas of family dysfunction clearly.
3. To help the members of the family work out effective ways of interacting with one another to replace the dysfunctional patterns.

Our approach is direct. We confront the families with their difficulties and speak in their own terms, avoiding professional jargon. Most members of these families have trouble recognizing or describing their

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feelings. We have found completely inappropriate the traditional casework question, "How do you feel about this?" Whenever we have slipped back into this technique, we have drawn a blank. Such a delving into feelings seems to block rather than build up our relationship with the family. We have, therefore, concentrated—with more success—on helping the family identify and look at the problem. We have found that this type of directness provides emotional support because it conveys our acceptance of the family as a partner and our confidence in the partner's ability to cope with the problem.

The team members seek out areas of conflict, points where communication is failing, and patterns of interaction, and then, in time, confront the members of the family with them. As problems are identified, the team both solicits and makes suggestions as to how the difficulties might be met. The areas of difficulty and the more adequate means of handling them are repeatedly underscored. As the sessions proceed, the members of the family are encouraged to talk among themselves rather than to the team members. The staff makes no attempt to identify or interfere with deep personality dynamics. The focus of attention is kept on the family's behavioral patterns and the possibility of substituting others.

Usually, the team meets with the entire family as a group, including the committed boy; but occasionally it separates the family into pairs or other groupings to facilitate the communication and clarify the individuals' understanding of what has been going on. However, before such separate sessions are held, all members of the family are told that any important understanding gained in the separate discussions will be shared with the entire family when the members come together again.

In one family of five, the mother completely dominated the group discussion with her expressions of concern about the boy in our charge. He was a ha-

bitual truant from school and had done some minor stealing. The mother said she was afraid that something "bad" ran in the family because her own brother had once been an inmate at the training school. She kept saying she could not understand why the boy would not go to school. The father sat somewhat removed from the rest of the group, listening, but saying nothing. The two girls ignored their father, gave the mother sullen looks, but hardly spoke at all. After a while, the group broke up; the mother and father each went into sessions with a different staff member and the three children went with a third.

In their separate sessions, the mother openly complained because the father, although a good provider, never helped control the children or actively showed affection; the children complained that their mother was too talkative and critical and that their father was a "nothing"; the father broke down and cried, saying that his wife made him feel like nothing, that the boy seemed to have more on the ball than he, and that he had never in his life really felt comfortable with anyone.

When the family reassembled, the mother was encouraged to ask the father for some help when she needed it; the children were given some glimpses of their father's loneliness; and the father was encouraged to speak up more and take a firmer hand around the house. In additional individual sessions, attempts were made to build the father's confidence in himself and to encourage him to reach out to the children.

The boy was ultimately paroled, completed school, and, at last report, was in military service doing well.

Occasionally, we make a followup 2-day visit to a family that has had a 2-day session at the school. During such a visit, we sometimes replay parts of a tape as a reminder of "where we were" and what had been agreed upon. Such followup visits were made, for example, to a family in which the parents had agreed to sit down to discuss family finances together at least once a month and the children had agreed to help them "remember" to do this. Followup visits were also made to a family whose members had agreed to take time to talk over feelings of hurt and anger toward one another at least once a week, but who needed much encouragement in doing so until they learned that they could be frank with one another and still survive.

During the first 14 months of our work with families as a whole, we met with 58 families. Resources did not permit a formalized study of results. Our impressions were, however, that we had some notable successes and some obvious failures. Our experience convinced us that family dysfunction can lead one or more of its members to adopt delinquent behavior. This seems especially true when the dysfunction is characterized by (1) low parental self-esteem; (2) communication failure between the parents; (3) communication failure between the parents and the children; (4) vague definition and inadequate performance of parental roles in division of labor within the family and in the provision of guidance, nurture, and support; and (5) relationship failures between the family and community authorities, such as school personnel, police, and social agencies.

A responsibility

Our program of family therapy was interrupted for several months because of other pressing obligations. We have, however, recently resumed it—this time as a research effort with some built-in methods of evaluating our methods of selection and approach. Our aim is to compare the institutional and post-institutional progress of experimental and control groups of 50 committed boys each. The families of the boys in the experimental group will be involved in family therapy. Boys in both groups will be administered tests early in their commitment, at the time of release, and 6 months after release. We will also seek to broaden our knowledge about the varied patterns in the families of delinquent boys and to learn new and more effective ways of helping them.

If, as we believe, the family plays a crucial role in child development, then a "delinquent" child may be symptomatic of a troubled family. This means that correctional workers have a responsibility to develop new ways of reaching out to hard-to-reach families and the resources for reaching as many as possible.

At the Iowa Training School for Boys, we have made the opportunity to get close enough to some families to reconfirm our conviction that nearly every human being wants to perform better than he does.

¹ MacGregor, Robert, et al.: *Multiple impact therapy with families*. McGraw-Hill, New York, N.Y. 1964.

BOOK NOTES

STUTTERING: learned and unlearned. Frank J. Falck. Charles C Thomas, Springfield, Ill. 1969. 160 pp. \$7.75.

Stuttering is learned behavior that can be unlearned, says the author of this book. He draws on his experience as a speech therapist and director of the Center for Disorders of Communication at the Medical Center Hospital of Vermont to present methods for changing such behavior. His plan involves efforts to help the patient "unlearn" stuttering through removal of his basic confusion regarding such behavior; breakdown of learned stuttering patterns that interfere with normal speech; reinforcement of learned patterns of normal speech; minimization of psychological and neurological causes of breaks in communication (called "nonfluency"); and reintegration of the personality to form a self-image as a normal speaker.

The author discusses ways in which stuttering is learned and the reasons for such behavior, as well as ways to prevent stuttering. The final section contains the author's answers to questions about stuttering frequently asked by stutterers, their families, and their teachers.

THE PSYCHOANALYTIC STUDY OF THE CHILD. Volume 23. Edited by Ruth Eissler, et al. International Universities Press, New York, N.Y. 1968. 479 pp. \$12.

This volume of an annual compendium of psychoanalytically oriented articles contains 21 papers divided into five sections: Problems of Psychopathology and Therapy; Contributions to Psychoanalytic Theory; Aspects of Normal and Pathological Development; Clinical Contributions; and Psychoanalysis and Jurisprudence. Among other papers, the section on development includes papers on character formation in adolescence, the development

of conscience, and parallels and differences in the development of blind and sighted infants. Among the clinical contributions are papers on the re-education of the retarded blind child and work with a blind child in a hospital.

The volume also includes an appreciation of the late Willie Hoffer, by Anna Freud.

PERSONALITY DEVELOPMENT AT PREADOLESCENCE: explorations of structure formation. Riley W. Gardner and Alice Moriarty. University of Washington Press, Seattle, Wash. 1968. 344 pp. \$9.50.

The major facets of the structuring of personality in preadolescence are explored in this book, which reports the results of a study of 60 boys and girls between 9 and 13 at the Menninger Foundation in Topeka, Kans. The authors, who directed the research, found that defense mechanisms and the organization of cognitive control are more fully developed at preadolescence than they had previously assumed; that no single group of variables is dominant in predicting other important aspects of behavior; and that evidences of individual consistency are impressive among preadolescents.

About half of the children in the study had participated from infancy in a larger longitudinal study project at the Menninger Foundation. The research team's assessments of the preadolescent children are based on a battery of tests for cognitive controls (leveling-sharpening, scanning, field-articulation, tolerance for unrealistic experiences, constricted-flexible control, and conceptual differentiation), performance consistencies in Holtzman Inkblot Tests, major areas of intellectual ability as determined by the Weschler Intelligence Scale for Children, behavior in both clinical and laboratory testing sessions, and defense mechanisms and general characteristics of ego organization.

The authors found no significant differences between the 31 girls and 29 boys in five of the six aspects of individuality studied. In the patterning of behavioral defense mechanisms, however, they report that boys tend toward greater use of isolation, reaction formation, and denial while girls tend toward greater use of repression.

The authors present case studies to illustrate the personality formation of children high in general ego strength and children low in ego strength. However, they clearly emphasize the extreme complexity of individual personality organization in preadolescence.

GROUP COUNSELING AND PSYCHOTHERAPY WITH ADOLESCENTS. Beryce W. MacLennan and Naomi Felsenfeld. Columbia University Press, New York, N.Y. 1968. 198 pp. \$6.

Small groups are particularly useful in working with adolescents because they provide a miniature real life situation that can be utilized for the study and change of an adolescent's behavior, according to the authors of this book.

In presenting methods of group counseling and group psychotherapy that can be used in everyday settings, the authors draw on their own experiences as a psychologist and a social worker in Howard University's Human Service Aide Training Program and in other work with adolescents. They point out that a member of a skillfully conducted group can evolve and test a new concept of himself, find new models for identification, and increase his self-esteem through the interaction with the other group members. Such groups, the authors point out, may be primarily concerned with information and orientation, specific problems and their resolution, patterns of general life adjustment demanding changes in self-concept and self-management, or indirect counseling arising out of other activities.

In separate chapters, the authors discuss the group as an agent of change, the adolescent culture, group interaction in counseling and psychotherapy, processes and maneuvers that adolescents use, major themes that recur in group discussions (career choices, relationship to authority, boy-girl relationships and sex, management of feelings, the peer group, and the law), groups in different settings, and leadership training.

HERE and THERE



Family planning

"We should establish as a national goal the provision of adequate family planning services within the next 5 years to all those who want them but cannot afford them," President Richard M. Nixon said in a message sent to Congress on July 18 on the problems the Nation faces in dealing with population growth. In addition to expansion of government activities related to family planning, he called for cooperation in this field with other countries under the leadership of the United Nations, and creation of a 2-year congressional Commission on Population Growth and the American Future.

Asserting that the wishes concerning family size are usually the same for women of childbearing age in low-income and higher income groups, the President pointed out that most of an estimated 5 million poor women do not now have adequate access to family planning assistance.

He emphasized the point that family planning services should not be allowed "to infringe upon the religious convictions or personal wishes and freedom of any individual."

Predicting that there will be more than 300 million Americans by the year 2000, the President recommended immediate action in the following areas—

1. Increased research on birth control methods and the sociology of population growth, with Federal research carefully related to that of private organizations, university research centers, international organizations, and other countries.

2. More trained people to work in population and family planning programs, both in this country and abroad.

3. Careful study of the effects of

population growth on the environment and on the world's food supply, with highest priority for developing and applying new techniques that can help safeguard the environment and increase the world's supply of food.

4. Expansion and better integration of domestic family planning services supported by the Federal Government—through increased expenditures for family planning services and "a clearer source of financial support"; the establishment of a family planning unit within the Department of Health, Education, and Welfare; the strengthening of family planning services sponsored by the Office of Economic Opportunity; and the coordination of HEW, OEO, and State and local efforts.

In proposing the Commission, the President suggested that it conduct investigations and make recommendations in three specific areas:

- The probable course of population growth, internal migration, and related demographic developments between the present and the year 2000.

- The resources in the public sector of the economy that will be required to deal with the anticipated growth in population.

- Ways in which population growth may affect the activities of the Federal, State, and local governments.

Family planning services are being extended to the poor in 41 States under 79 grants totaling \$12 million awarded by the Children's Bureau in the 1969 fiscal year. Grantees include 32 State departments of health, 31 county and city health departments, nine medical centers and hospitals, and seven planned parenthood organizations.

The projects are designed to give a

choice in planning the size and spacing of their families to couples with low incomes, to improve maternal health, and to reduce infant mortality. Most of the projects are located in model cities project areas or in other areas with high infant mortality rates.

The Children's Bureau supports other family planning services through State health department maternal and child health programs and maternity and infant care projects. In the 1968 calendar year, these programs brought family planning assistance to more than 420,000 women. In addition, States may offer family planning services through Medicaid and must offer such services to women in their programs of aid to families with dependent children.

Child development

A Center for Child Development and Education in Little Rock, Ark., is opening this fall to provide children between 6 months and 12 years of age from low-income families with continuing opportunities for intellectual, physical, and social growth. The center, jointly operated by the University of Arkansas and the Little Rock Public Schools, has been awarded a grant of \$330,394 by the Children's Bureau for the first year of operation. Its director is Bettye M. Caldwell who in the Little Rock center is continuing research in cognitive, social, and emotional development that she began at Syracuse University.

The Arkansas project is being undertaken both to test research findings indicating that disadvantaged children benefit most from developmental programs begun in preschool years and to devise new approaches to meet the developmental needs of infants and young children.

Enrollment for the first year will include 75 infants and toddlers, 75 preschool children, and 150 elementary school children.

The project will provide day-care services, kindergarten, elementary school classes, recreation activities, special education, and tutoring services. Children of any age may receive day care for part or all of the day between 7 a.m. and 6 p.m., without adhering to a rigid schedule. Very young children who participate in the research project will be tutored at home by center staff and will also attend short "infant classes" at the center.

The center will serve not only as a demonstration facility for early childhood education, but also as a training facility for teachers and research workers. Its building will be available during evening hours for use by neighborhood residents.

Educational television will direct a new series of programs to the Nation's 12 million preschool children between 3 and 5 years of age in an \$8 million, 2-year experiment starting November 10. The Children's Television Workshop, an affiliate of National Educational Television, of New York City, will produce the series, "Sesame Street," featuring puppet shows, story readings, animated cartoons, action films, and 1-minute commercials that teach letters of the alphabet.

The Workshop will offer a series of 1-hour shows, 5 days a week, for 26 weeks. Most of the 163 NET stations in the country will carry the programs at times convenient for viewing by children in day-care centers, Head Start, and nursery school programs, as well as those at home.

The series is designed for all preschool children, but will focus on preparation of disadvantaged children for school. Teaching letters, numbers, words, and geometric forms will have top priority in programing. Problem-solving, reasoning, concentration skills, and basic science studies will also be included.

The programs are to be cooperatively financed by four Federal agencies—the Office of Education, the Office of Economic Opportunity, the National Institute of Child Health and Human Development, and the National Endowment for the Humanities, and private organizations, including the Carnegie Corporation and the Ford Foundation.

Child abuse

A nationwide survey shows that 5,993 incidents of physical abuse of children were reported to official agencies under child abuse reporting laws in the 50 states during 1967, and 6,617 incidents during 1968, according to David G. Gil, director of a continuing epidemiological study of abused children supported by the Children's Bureau and conducted by Brandeis University. Cases of sexual abuse were excluded from the study

President's Message on Assistance

As this issue went to press, President Nixon's welfare message was received by Congress. In brief, the President proposed that—

- The Federal Government pay a basic income to all families with children who cannot adequately support themselves. For a family of four, the Federal payment could be as much as \$1,600 a year.

- Incentives for working be provided by allowing \$60 a month (or \$720 a year) of earnings to be disregarded in computing the benefits of a family with an employed member and only reducing benefits of families earning more than \$720 a year by a percentage of the remaining earnings. For a family of four with earnings of \$1,000, the total income would be \$2,460; if the family earned \$2,000, the total income would be \$2,960.

- There be no eligibility requirement that denies benefit to intact families with a father employed full time.

- All employable persons who receive benefits, except mothers of preschool children, be required to accept work or training.

- A major expansion of job training and day-care facilities be made available.

- The States where the basic payment is less than the present Federal-State payments be required to maintain current levels of benefits and be indemnified against non-Federal costs in excess of 90 percent of their public assistance costs under existing law.

- States be required to continue for 5 years to spend at least half of what they are now spending on public assistance.

unless physical abuse was a major factor.

The reports showed that more boys (53 percent) were abused than girls (47 percent). The children ranged in age from infancy to 19 years. Each of the following age groups had about one-fourth of the cases: under 2, 2 to 5, 6 to 9, and 10 to 19. The survey found that repeated abuses in 1967 were reported for only 41 children.

An analysis of 1,350 incidents reported in 30 communities showed that—

- About 90 percent of the incidents of child abuse occurred in the child's own home.

- A parent was the perpetrator in 87 percent of the incidents—the mother in 48 percent and the father in 39 percent.

- A brother or sister witnessed the abuse in 62 percent of the incidents and the mother in 26 percent.

- About 11 percent of the parents were known to have been abused as children.

- About 90 percent of the abuses did not cause lasting physical injuries. In about one-fourth of the cases, children did not need medical treatment and in

60 percent of the cases, children did not need hospitalization. Seven percent of the abused children had to be hospitalized for more than 1 month. Very young children tended to be more severely injured than older ones.

- Most incidents involved beatings—39 percent with hands and 44 percent with instruments; 9 percent involved burning or scalding. About 14 percent showed characteristics of the battered child syndrome—that is, evidence on X-ray of bones having been broken in the past.

- The perpetrators themselves sought help for the abused children in 21 percent of the incidents.

- At least 35 percent of the children had been subject to known abuse before 1967. For an additional 50 percent, the history of abuse was unknown.

- About half of the children and at least 60 percent of the parents showed noticeable deviations in social, behavioral, physical, or intellectual functioning in the year before the abusive incident.

- About 75 percent of the fathers and 80 percent of the mothers of the abused children had not finished high school;

28 percent of the families had incomes of less than \$3,000 and 52 percent of less than \$4,500; 37 percent had four or more children; and 50 percent had lived in their present homes for less than a year.

• About 63 percent of the abuses developed out of disciplinary action taken by a parent, and 11 percent developed out of a quarrel between the parents. In 13 percent of the cases, the perpetrator was drunk.

About 36 percent of the 1,380 children reported as abused in the 30 communities were later placed in other homes; in 15 percent of the cases, brothers and sisters were also removed from their homes. About three-fourths of the families received counseling services after the abuse occurred. The perpetrators of abuse were indicted in 17 percent of the cases and in 7 percent were jailed after conviction. While 66 percent of the children in the entire survey were Caucasian, in the 30 communities—including nine densely populated metropolitan areas—46 percent of the abused children were Negro, 39 percent Caucasian, 7 percent Puerto Rican, 4 percent Mexican, less than 1 percent each American Indian or Oriental, and 2 percent were classified as "other."

The project, which is to continue until 1970, is now analyzing figures on child abuse reported in the 50 States during 1968.

Mental health

With a primary recommendation for the establishment of a nationwide system of "mental health advocacy" for children, the Joint Commission on the Mental Health of Children presented a report to Congress on June 30 on the findings of its 3 years of study on the mental health needs of children in this country.

Organized through the cooperative action of 13 professional and scientific groups in response to 1965 legislation authorizing Federal expenditures for studies relating to emotional illness in children, the commission is a nonprofit corporation whose work has been supported with grants from private foundations and the National Institute of Mental Health. It consists of a 54-member multi-disciplinary board that has worked through six task forces, four substantive committees, a small staff, and an array of consultants.

The "advocacy system," recommended by the commission, would consist of a network of State and local child development bodies—"partially" federally supported—which would study children's needs and stimulate responsible organizations and groups to take action to meet them. At the top would be a Presidentially appointed Council of Advisers on Children and Youth charged with long-range planning, policymaking, and programing for services and manpower and with advising the President and Congress on the allocation of monies spent for children and their families. The State Child Development Commissions would devise statewide plans for the provision and coordination of services to children and evaluate the work of local services. The local Child Development Authorities would be charged with the stimulation and coordination of local services and would include representation from the consumers of service. Neighborhood Child Development Councils would serve as direct advocates for children, seeing that they receive the services they need.

The commission also recommended that the Federal Government support the creation of a network of systematic and comprehensive services of a supportive, preventive, and remedial nature, giving high priority to family planning and birth control services, prenatal care, comprehensive pediatric and supportive services for children, and remedial mental health services. Among other proposals for the improvement of social services, it places emphasis on the creation of a publicly supported day-care system available to all children and their families. Its several proposals concerned with education include a recommendation that education be extended as a "public utility" to children from their preschool years through junior college.

The commission also recommended the development of a Federal policy to deal with the shortages in professional manpower, the Federal support of professional training facilities, the subsidization of students in training, the increased training and use of paraprofessional personnel, and the use of tax incentives to facilitate an equitable geographic distribution of professional manpower.

Among other recommendations concerned with research, the commission

urges the establishment of 10 federally supported child mental health research centers under the auspices of either the National Institute of Mental Health or the National Institute of Child Health and Human Development.

The full report of the commission is being published by Harper & Row early in 1970 under the title of "Crisis in Child Mental Health: The Challenge for the 1970's."

Public assistance

On June 30, the 91st Congress repealed a law that would have frozen Federal payments to States under the program of aid to families with dependent children (AFDC) at 1968 levels, beginning July 1, 1969. The freeze on AFDC payments was originally set for July 1, 1968, but was postponed by Congress for 1 year before it took effect. If the freeze had been imposed in 1969, it would have cost the 50 States an estimated \$332 million above present expenditures to maintain AFDC services at their current level for the 1970 fiscal year.

. . .

An injunction that prevented the State of New York from reducing the amount of its monthly payments to AFDC recipients was lifted by the United States Court of Appeals for the Second Circuit in a 2-to-1 decision on July 16. The plaintiffs have indicated that they will appeal the case to the Supreme Court of the United States.

The suit was brought against the State by 10 residents of New York City and Nassau County, after their assistance payments were cut an average of 8.5 percent as authorized by the State Legislature in March. A Federal court in Brooklyn, in issuing the injunction against cuts in payments, held that the State could not reduce the standard of need once such a standard had been established.

The appeals court voided the injunction, ruling that the lower court exceeded its authority in issuing it. One judge found that the 1967 amendment to the Social Security Act only required each State to adjust its standard of need for AFDC recipients by July 1, 1969, and did not require any State to pay the full amount of its adjusted standard of need nor to increase its AFDC payments. In a dissenting opin-

ion, another judge suggested that "Congress intended AFDC payments throughout the country to be increased somewhat to reflect the rise in the cost of living and that the levels of payments so adjusted were to remain stationary at least pending further congressional action."

Recipients of public assistance in New York City received the first issue of a monthly newsletter along with their June checks. The 3- by 7-inch folded sheet, called *Checkmate*, printed in English on one side and Spanish on the other, is published by the Department of Social Services of the City of New York.

Subprofessional aides

Two part-time welfare aides in the Coos County, Oreg., Public Welfare Department are currently drawing on their past experience as foster mothers to provide services to foster families and to improve communications between foster parents and caseworkers. The aides, who were hired last fall under a project funded by the Children's Bureau, performed so satisfactorily that the welfare department added both of them to its permanent staff on July 1, 1969.

One aide regularly relieves the foster parents in temporary shelter homes for a few hours each week and provides homemaking services and child care in shelter and foster homes when the foster parents need to take a child for medical treatment or to be away for other reasons. In emergencies—such as a death—she moves into a foster family home for a few days to take care of the children. She also furnishes transportation for children from rural areas to doctors' offices, clinics, courts, and other service agencies and helps select clothing for children coming into care.

The second aide assists the department's foster home finder and other caseworkers in the foster care unit. In addition, she works with foster parents who are having problems with teenagers—an area in which she has special skills—helps conduct monthly meetings for foster parents, helps recruit and train new foster parents, and explains the county's foster care program to community groups.

The need for help for social workers in the foster care unit arose from the

large workloads, plus the long distances that workers must travel in the county. The idea of using experienced foster mothers as part-time workers was developed by Lois McCarthy, then family and child field representative, and Mrs. Lee Wentworth, family and child supervisor for the Coos County department.

Both aides were selected for their ability to work with people and for their special knowledge of foster family care; both quickly established a rapport with foster parents.

Rehabilitation

Nearly 900 persons attended the National Citizens' Conference on Rehabilitation of the Disabled and Disadvantaged held in Washington, D.C., June 24-27. They represented a wide variety of special interests, were of many races and nationalities, and came from many different walks of life. They included wealthy volunteers and mothers who are receiving public assistance; blind persons, paraplegics, and persons with other physical defects; ex-convicts and ex-drug addicts; businessmen and labor leaders; members of Congress and State legislators; administrators of both public and voluntary agencies; and representatives of almost all of the helping professions—teachers, physicians, nurses, lawyers, and social workers.

The conference was planned and organized by a committee whose members had similar backgrounds to the participants. It was supported by the Department of Health, Education, and Welfare through the Social and Rehabilitation Service (SRS), which paid the expenses of many disabled and disadvantaged participants who could not otherwise have attended.

In welcoming the conferees, Vice President Spiro T. Agnew noted that there are still many citizens for whom "the American dream is a nightmare," and maintained that society must compensate for their handicaps; and Mary E. Switzer, Administrator of SRS, urged the conferees to help the Federal Government's efforts to "bridge the gap between the ghetto and the rest of the community."

Drug use among the young received attention both in the general sessions and in the many small discussion groups that comprised the major portion of the conference. An 18-year-old ex-drug ad-

dict told of 4 years of addiction, begun at the age of 13. Now a staff member of the Addicts Rehabilitation Center in New York City's Harlem, he urged the conferees to "take the drug problem home with you; work with the kids and their parents." Another ex-addict, now a TV performer, said that "old devil drug" had at least achieved something in bringing black and white, ghetto and suburb together.

The ultimate solution to the drug problem, the discussants agreed, would have to be an attack upon the rich and powerful syndicates, rather than the small-time peddlers, pushers, and users.

Two general sessions speakers who stressed the necessity for a change in national priorities from foreign to domestic needs received standing ovations: Whitney M. Young, Jr., executive director of the National Urban League, who gave the keynote address, and Martin Agronsky, TV news commentator. Mr. Young called upon the delegates to form themselves into a "coalition of the concerned" to bring about the needed change. Mr. Agronsky maintained that despite many governmental programs "the poor get less out of the 'welfare state' than any group in America."

A number of unscheduled caucuses drew attention to minority groups and their needs, including Negroes, Spanish-speaking people, and welfare recipients.

A major part of the conference consisted of the presentation of audio-visual materials. Color films dealt with such topics as methods of organizing and financing day-care centers, cooperative rehabilitation centers, and job training centers; services for the rural poor, the deaf-blind, and people with emotional problems and other handicaps; consumer involvement; architectural barriers to the disabled; systems for delivering services. Prints of the films are available through SRS.

A report of the conference and the papers prepared for it will be published by the Social and Rehabilitation Service.

notice to libraries

The index for articles in CHILDREN during 1968 (Vol. 15) should include the following entry:

Gil, David G.: Mothers' Wages—One Way To Attack Poverty, Nov.-Dec., 229.

IN THE JOURNALS

Therapeutic abortion

During 1968—the first full year in which California's liberalized abortion law was in effect—the San Mateo County General Hospital, San Mateo, Calif., reported a marked increase in the number of legal, in-hospital abortions. Phyllis Bailey Thurstone, M.D., says in the July 14, 1969, issue of *JAMA*, the journal of the American Medical Association. ("Therapeutic Abortion.") She reports that 55 therapeutic abortions were approved at the hospital in 1968 in contrast to nine in 1967, and five in 1966.

The author also points out that in 1968 at San Mateo the incidence was 98 therapeutic abortions per 1,000 live births, compared with 11.2 abortions per 1,000 live births for the State of California. Reasons for approval of the requests for abortion at San Mateo in 1968 included physical health, two; statutory rape (girl was under 15 years of age), five; and mental health, 45 (86 percent). Five applicants were refused.

Dr. Thurstone lists the following characteristics of the patients on whom abortions were performed at San Mateo: age range from 13 to 46, with a median age of 22; first pregnancy, 22; six or more pregnancies, 9; never married, 31 (almost 60 percent); Caucasian, 48; Negro, 10; Caucasian-Oriental, 2; first 12 weeks of gestation, 80 percent. Only three of the applicants were not residents of California.

Welfare service aides

The training and hiring of mothers from the program of aid to families with dependent children (AFDC) to assist public welfare workers in providing services to other families in the program may be one way of improving social services to the poor, writes Dorothea Cudaback in the July 1969 issue of *Social Work*. ("Case-Sharing in the AFDC Program: The Use of Welfare Service Aides.") In her article she re-

ports on the success of a demonstration project in the Alameda County (Calif.) Welfare Department in which 10 mothers on AFDC were given a 10-week training course, after which they were employed by the department as full-time welfare service aides.

Seven of the aides were assigned to work on a team basis as full-time aides in the AFDC program. They performed such tasks as counseling mothers on money management, child care, home-making, nutrition, and where to find family planning service; communicating with resistant clients; helping mothers find better housing; helping applicants complete eligibility forms and verify eligibility; making required renewal or review visits to clients' homes; providing emergency transportation for clients; and providing information about welfare policies and services. The overall responsibility for serving clients on the AFDC caseloads remains with the welfare worker, who determines if and when the services of the aides are needed, and what kinds of services.

Advocate for the child

A child needs a spokesman, or advocate, to represent his own best interests in custody proceedings, says Thomas A. Coyne in the May 1969 issue of *The Annals of the American Academy of Political and Social Science*. ("Who Will Speak for the Child?") The author, an assistant professor at California Western University School of Law, suggests that the child is still being treated by the courts as property that results from a marriage, not as a human being.

Courts now require that a guardian be appointed to speak for a child who is a party to a civil suit, the author points out. "Surely . . . that same child should have a spokesman when the matter being decided is his environment while he is developing into an adult," Mr. Coyne says. He suggests that the custody proceeding be made a "truly adversary proceeding" in which the counsel would

assess the health, personal, and educational needs of the child and report to the judge both the findings and recommendations as to the best interests of the child.

The author cites several cases arising from malfunctioning of the family. "What the court is actually called upon to do is to play God with respect to a child," he maintains. Pointing out that courts follow the general rule that parents—unless unfit—have the right to the custody of their children, he cautions that a presumption of parental right should not outweigh the best interests of the child.

The entire May issue of *The Annals* is focused on "Progress in Family Law."

Combating drug abuse

To combat a sudden upsurge of drug abuse among young people in Bloomfield, Mich., the Youth Bureau of the city's Department of Public Safety is mobilizing parents, young people, schools, and police in efforts to educate the community against the hazards of drug abuse and identify users and trouble spots, reports Jerry J. Tobias, director of the department's juvenile services, in the July 1969 issue of *The Police Chief*. ("Drugs in the Suburbs.")

As evidence of the seriousness of the problem, he points out that the Youth Bureau had contacts with 100 youthful drug users in 1968. The author estimates that the figure will double in 1969. He also cites estimates that half the young people in Bloomfield—a Detroit suburb of some 40,000 persons—may have experimented with drugs.

The police department's efforts, as described in the article, have included enlargement of the Youth Bureau's staff; the employment of a police-school liaison officer to work with the schools in informing young people about the hazards of drug abuse; the establishment of a drug clinic, with the focus on community education in regard to drug abuse; the sponsoring of drug seminars to help teachers and other school staff members recognize drugs and drug users; and publication of a booklet describing parents' responsibilities for seeking help from the Youth Bureau when they suspect their children of using drugs.

The author reports that along with these educational efforts, the department has stepped up its activities to identify drug users and sellers.

NOVEMBER • DECEMBER 1969

children

Early Malnutrition and Development

Communicating With Today's Teenagers

Families for Institutional Children

Retarded and Normal Children at Camp



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Mothers, like babies, need to be well nourished, as this little girl seems to realize instinctively. (Or is it that she just needs help in getting rid of all that milk?) In any case, her brightness indicates her mother has been feeding her well and realizes the importance of good nutrition in early childhood. What is known and not known about the effects of malnutrition on early development are reviewed in the lead article in this issue.

children

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DELBERT H. DAYTON

● The effects of malnutrition on human physical growth and mental development are of great concern today not only in less affluent countries of the world but also in the United States. However, while many studies on malnutrition have been carried out in various parts of the world, there is still a great lack of knowledge regarding the importance of proper nutrition to specific aspects of growth and development.

Investigators continue to search for knowledge of the critical developmental periods during which malnutrition produces organic change. If such change is produced by nutritional deficits, however, there are still the questions of whether it is reversible or permanent and of whether or not it alters the affected child's functional capacity. Studies are needed not only to answer such questions about nutritional effects but also to answer questions about the physical, biological, and sociocultural factors that also influence growth and development and are intimately related to nutrition.

One study that promises to produce important information is currently being carried out in Guatemala among matched groups of children from three rural villages where extreme malnutrition is prevalent. These children will be studied closely from birth until they are 7 years old. In each village, newborns will be assigned to one of the two groups. The children in one group will live on the customary diet of the people in the area; the children in the other group, matched

EARLY MALNUTRITION and HUMAN DEVELOPMENT

with the first on many important variables, are being provided a nutritious supplement. The comparison of the two groups of children as they grow older will provide important data not available from cross-sectional studies. Multifocused and interdisciplinary, the Guatemalan study involves the behavioral as well as the biologic sciences.

In the United States, two nutrition surveys are being supported by the Department of Health, Education, and Welfare (HEW), one through the Public Health Service under the direction of Arnold Schaefer, chief of HEW's nutrition program, and the other through a Children's Bureau research grant under the direction of George M. Owen, associate professor of pediatrics at Ohio State University. Although neither of these studies has been completed, their preliminary data indicate that malnutrition among certain groups of children also exists in the United States. The problem in the United States differs in cause and degree from that in less affluent countries and so requires different methods for solution, but the basic questions needing to be answered about the effects of malnutrition on growth and development of children are the same. New or improved nutrition programs will need to be organized wherever malnutrition exists, but these will be most useful if they are designed not only to serve the needs of malnourished people, but also to establish a baseline of information from which their success or failure can be measured. Evaluative methods built into such pro-

grams could help answer many remaining questions about the specific effects of malnutrition.

For many years there has been controversy among biomedical scientists regarding the effects of a woman's nutritional status on the product of conception. Until the Second World War, it was generally believed that the health status and nutritional status of women during pregnancy were of minor importance to fetal development. The fetus was considered to be a parasite that could obtain all it needed from even a nutritionally deficient mother. However, this assumption began to be questioned after the war when analyses were made of the records of malnourished women in Holland¹ and other parts of Europe^{2,3} who gave birth during periods of extreme wartime starvation. In Holland, the median birth weight of the babies born in these periods was 240 grams less than the birth weight of prewar babies, and birth length was also less, but the decline in birth length between the prewar and wartime periods was much less than in birth weight. Other studies have shown varying decreases in birth weights between the prewar and postwar periods, but the weights remained within the normal range for full-term newborns.

Further information on the effects of maternal nutrition on fetal development is needed to determine whether a small difference in birth weight makes a difference in the child's prenatal and postnatal development and functioning. Studies in this area are

especially important since maternal malnutrition is known to be associated with increased rates of morbidity during pregnancy and of premature delivery. However, a cause-and-effect relationship between maternal malnutrition and either morbidity or prematurity has not been established. Many other factors that might also be contributing to these phenomena exist in areas where malnutrition is endemic.

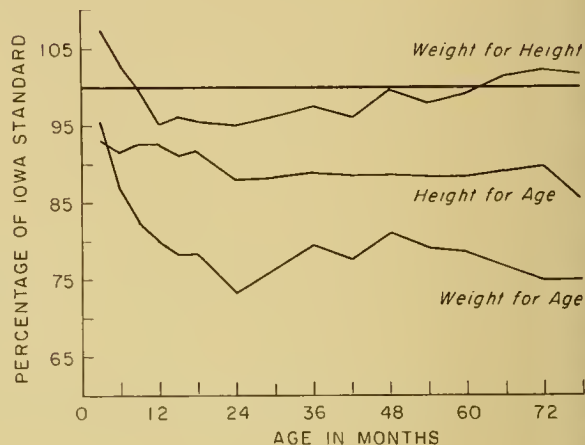
In studies of maternal malnutrition, it is important to distinguish between an acute, sudden onset of malnutrition of a specific duration in a population—as in a war—and the type of chronic malnutrition that exists in developing countries. Evidence is increasing that the nutritional experiences of the potential mother before conception may also be extremely important to subsequent intrauterine growth. This means that where malnutrition occurs in critical periods of development, such as adolescence, future generations may be affected.

Various studies have shown differences in birth weights according to socioeconomic status within the same ethnic group. Their results are complicated by sample bias caused by the inclusion of hospital patients or the inclusion or exclusion of premature infants. However, in most studies of Europeans and North Americans, mean birth weights are about 3,300 grams, whereas mean birth weights in other populations are nearer 3,000 grams.⁴ Because of the wide variation in normal birth weights within any one group, such differences are difficult to assess. Better knowledge of body composition and stores of nutrients within the bodies of the children in these two groups would be helpful.

Some studies have shown that breast-fed infants from areas in various parts of the world have patterns of growth during the first 6 months of life very similar to well-nourished infants in North America.⁵ Many studies in developing countries also suggest that growth progresses satisfactorily during the first 4 to 6 months of life while the child is breast feeding and the mother's milk supply is adequate. But growth normally progresses rapidly in infants, and after 6 months, or even sooner, breast milk alone may become inadequate to sustain a child even when the mother's milk production is maintained. Where the mother's milk is not supplemented with other foods, the growth patterns of breast-fed children begin to diverge from the North American standards. Studies have shown that even though growth velocity normally slows down at a later age, the child may never be able to catch up to the original growth curve.

Small size per se is not what matters to the health

IOWA HEIGHT AND WEIGHT STANDARDS 400 RURAL GUATEMALAN MALE PRESCHOOL CHILDREN—1967



of the child, but what may go with it—possible changes in metabolic pathways, body composition and ultimate functional ability. If such changes do occur, research is needed to determine the most critical periods for growth failure and whether change that occurs in these periods is reversible. In many developing countries, it is not uncommon for breastfeeding to continue throughout the first 18 to 24 months of life and supplementation of the diet with solid foods to be inadequate and begun late. If the supply of maternal milk is insufficient or if the mother is unable to nurse, the life of the infant is greatly jeopardized, for inadequate substitution of other food may result in serious protein malnutrition and poor hygienic conditions may result in fatal infection from contaminated, prepared formulas. This underscores the great importance of a good supply of breast milk for such infants—a supply which seems to be related to the nutritional status in the mother. In the United States where formulas are extremely popular, insufficient breast milk supplies and unsanitary feeding conditions are not such a great problem. But mothers need to be made fully aware of infant nutritional needs during the early months when growth and development proceed rapidly. Children

in certain poverty-stricken groups of the United States appear to have the same nutritional problems at the age of weaning as children in developing countries.

A composite picture of the growth patterns in some 400 male children from 1 month to 78 months of age in rural Guatemala is shown in the graph on page 212. A similar pattern has also been found in a sample of female children of the same age and background. The diets of these children were significantly deficient in calories, protein, riboflavin, and vitamin A.⁶ The straight horizontal line at 100 percent in the graph represents the mean weight for age, height for age, and weight for height of children studied in Iowa, known among nutritionists as the Iowa growth standards.⁷ Birth weights are not available from the Guatemala study. The graph shows that both weight and height for age in Guatemala fall below the Iowa standards throughout all ages, but the deficit is very small in the first few months of life. But when the child's weight is considered in relation to his height, regardless of the standard for his age, the Guatemalan children follow the Iowa standards more closely. However, the Guatemalan children are very short, which may be a result of malnutrition. Therefore, when their weight is considered even in relation to such a substandard height, they still show a weight deficit from the latter part of their first year until they are about 42 months old.

This graph brings out the marked importance of the second year of life in demonstrating growth deficits. At this age, the child is still dependent upon others to supply his nutrients and cannot fend for himself. He is affected by food taboos and cultural patterns that dictate what his family considers to be proper food for him. He is constantly exposed to infectious agents, especially when he lives under poor hygienic conditions. And if a second child comes

along at this time, he loses the maternal milk supply that may be acting as the sole source of protein in a meager diet. This is the age when the classic picture of severe protein malnutrition (kwashiorkor) frequently becomes evident.

Mental development

There is a great deal of concern today over the possible effects of malnutrition on mental development. This can readily be understood in view of the great numbers of children in the world who are malnourished and who, therefore, may not only fail to achieve optimal physical growth, but may be unable to realize their full potential for mental maturation.

Studies of animals have shown that the effects of malnutrition on the nervous system and total body growth are dependent upon the time, duration, and the severity of the nutritional deficit.⁸ Throughout the life cycle there is an orderly development of body tissues. Certain tissues seem to have a higher priority for development at particular times of life during which they are more vulnerable to the insult of malnutrition. The level of functioning of the endocrine system may also affect growth patterns modified by malnutrition.

Today tissue growth can be measured indirectly by determining the number of cells within a given organ. Since the amount of desoxyribonucleic acid (DNA) within the nucleus of a cell is constant for any given species,⁹ the total number of cells can be calculated by measuring the total amount of DNA within an organ.

Studies of animals have indicated that growth in all organs occurs in three phases: (1) hyperplasia, during which the number of cells increases; (2) hyperplasia and hypertrophy, during which the number of cells continues to increase and the size of the individual cells also increases; and (3) hypertrophy, where growth occurs only by increase in cell size.¹⁰ These studies suggest that during the phase of hyperplasia, malnutrition can interfere with cell division, resulting in fewer cells in the brain, which seems to be a permanent effect, whereas malnutrition during the phase of hypertrophy results in a smaller than normal cell size, which can be corrected by providing adequate nutrition.¹¹ Therefore, the nutritional status during the phase of hyperplasia, in the early periods of nervous system development, would seem to be exceedingly critical.

In humans the greatest growth spurt for the brain occurs during the fetal period. By the end of the first

Delbert H. Dayton, M.D., pediatrician, is a research associate in the Growth and Development Branch, National Institute of Child Health and Human Development, National Institutes of Health. Before assuming his present position in 1967, he spent 3 years at the Institute of Nutrition for Central America and Panama in Guatemala, under Public Health Service contract, helping set up a longitudinal study of the effects of malnutrition on physical growth and mental development. He has also specialized in work with mentally retarded children at the Pediatric Department, University of Washington, Seattle.

year of life, the brain has assumed approximately 70 percent of its adult weight, and by the end of the second year its growth is almost complete. Studies of the human brain have shown a very rapid increase in DNA content toward the end of the period of gestation; the increase slows down after birth but continues until the child is 5 or 6 months of age.¹² These findings suggest that cell division in the brain normally occurs during gestation and the early part of the first year of life. Markedly fewer cells (less DNA) were found in the brains of a small sample of children who died of malnutrition during the first year of life than in the brains of a sample of well-nourished children who died in accidents.¹² It is not known whether this represents irreversible change or how severe the nutritional deprivation must be to show these effects. But, the studies demonstrate the importance of gestation and early infancy in nervous system development.

Validation needed

These results must be validated in larger studies. Furthermore, such biochemical studies of malnourished children need to be coupled with detailed information about the mothers' pregnancies, the severity and duration of the malnutrition and the periods of gestation and early life in which it occurred, and the health and nutritional status of the mother. Such studies also need to be related to the level of the child's later mental functioning. Past studies of intellectual development in malnourished children have shown significant differences on mental tests between malnourished children and better nourished children in control groups.

For example, Stoch and Smythe,^{13, 14} in Capetown, South Africa, compared a group of children so severely malnourished as to be marasmic with a control group matched for age and sex. Both groups represented children from the lower socioeconomic level. After an 11-year followup during which the diets of the experimental group were improved, the group that had been severely malnourished continued to show significantly lower results than the control group on physical measurements (height, weight, and head circumference) and on various intelligence tests.

Differences were especially significant in visual-motor ability and pattern perception, when measured by the new South African Individual Scale. Because of inadequate dietary information during the later part of the study, these deficits cannot be explained

on the basis of early malnutrition alone. Moreover, differences in the social environment of the two groups were variables that could also be responsible for part of the difference found on mental tests. However, the smaller head circumference in the malnourished group, suggests that a stunting of brain growth may have resulted from malnutrition during the period when brain growth is normally rapid.

In Guatemala, Klein¹⁵ compared a rehabilitated group of severely malnourished children with a similar group of children who had never manifested overt signs of severe malnutrition. He demonstrated differences between these groups on a battery of psychological tests in items involving short-term memory.

Cravioto,¹⁶ using Gesell's methods, studied a group of 20 Guatemalan infants and preschool children who had recuperated from severe protein malnutrition, following some of them 6½ months. These children scored lower than a control group of children matched for age and ethnic background, who had never manifested signs of severe malnutrition. As the children grew older, the differences between the two groups became less marked in the areas of adaptive, motor, language, and personal-social behavior except for those who suffered malnutrition very early in life. Infants who had recovered from severe malnutrition before they were 6 months old continued to show deficits throughout the study. These studies also suggest that early malnutrition during the period of rapid brain growth might produce permanent mental deficits.

In a later study of rural Guatemalan children from 6 to 11 years of age, Cravioto correlated stature with neuro-integrative function.¹⁷ Ranking the children by height for age, he selected one group from the quartile including the shortest for age and another from the quartile including the tallest for age. All the children were from the same rural village and of the same ethnic background. The children from the lower quartile for height produced a greater number of errors on intersensory testing, but these differences diminished with increasing age. However, these studies do not provide evidence that malnutrition alone was responsible for the differences in intersensory testing since social impoverishment may also have been a factor. A similar study of a group of upper class urban children, also in Guatemala, did not demonstrate such differences associated with stature.

Further studies of mental development in malnourished children as measured by psychological

tests are needed. At present, almost all available information comes from cross-sectional studies of children and very little from longitudinal studies that follow the same children over an extended period of time. Without information from longitudinal studies, it is difficult to prove a cause-and-effect relationship between nutrition and mental development. Many factors other than nutritional status can affect a child's mental functioning—parent-child relationships, parental expectations, intellectual stimulation, infectious diseases, parental intelligence, socio-cultural patterns, and other genetic and environmental factors. The longitudinal approach to research is also necessary to determine the periods of life when mental development is most vulnerable to malnutrition, the degree and duration of malnutrition required to produce functional change, and whether or not such change is reversible.

Nutritional assessment

Growth retardation and various clinical syndromes resulting from malnutrition in animals and man have been described in the professional literature for many years. In 1931, Cicely Williams first described the syndrome now called kwashiorkor when she was working in the part of Africa then called the Gold Coast (now Ghana). Although kwashiorkor involves multiple nutritional deficiencies, the major cause is an extremely inadequate intake of protein foods. Dr. Williams not only described the main clinical features of kwashiorkor, a condition that if unchecked leads to marasmus and eventual death, but she also produced cures by feeding milk to children suffering from it, thereby showing that this was a disease of malnutrition.

Surveys to determine the prevalence of protein-calorie malnutrition followed in Africa,¹⁸ Central America,¹⁹ Brazil,²⁰ and other parts of the world. Their findings suggest that perhaps two-thirds of the children in developing areas of the world are not obtaining enough to eat. This does not mean that these children are all suffering from kwashiorkor. On the contrary, probably only 5 to 10 percent at any given point in time can be shown to exhibit this severe form of malnutrition. But it would not be unrealistic to state that at least 50 to 75 percent of the children in the developing countries have a degree of malnutrition that has caused physical growth failure as evaluated by height and weight data and assessment of bone development. Nutritional problems in the United States, though less extensive, do exist.

An assessment of the nutritional status of a population, including identification of deficiencies, is essential for sound social and economic planning. As a first step in such an assessment, it is important to find out what kind of food is available to the population, how food is distributed between different socioeconomic groups, and how and what the patterns of consumption are in these groups. A review of morbidity and mortality data will identify the groups within the population that are at high risk of malnutrition. Dietary surveys of individuals or families in a selected sample of these groups can provide much pertinent information. Clinical nutritional examinations, anthropometric studies, and bone X-rays can provide information on deficits in health and in physical development, while biochemical studies can aid in evaluating nutritional status and in determining recent nutrient intake.

In studies of bone maturation, radiographs taken of the hand, to determine the cortical thickness of the second metacarpal bone, and of the wrist, to identify the order and timing of appearance of ossification centers, have shown significant differences between well-nourished populations and poorly nourished populations.

An alert, healthy baby, like this one, is a baby who receives sufficient nutritious food—a condition unmet for millions of infants in the world's areas of poverty.



Biochemical determinations in population surveys permit assessment of adequate or inadequate protein intake for the total population. At present, however, these biochemical tools are incapable of identifying protein deficiency in an individual child until shortly before the onset of overt kwashiorkor. This is because there is a wide range of normal values among individuals and also because the homeostatic mechanisms of the body compensate for nutritional deficits until the point at which the internal equilibrium is overwhelmed and biochemical disease results.²¹ Therefore, still more sensitive tests are needed for the evaluation of individual nutritional status.

At present, in assessing the nutritional status of an individual child, the guide most frequently used is evaluation of height and weight over a period of time and comparison of this pattern of growth with previously established growth standards based on a well-nourished sample. Any marked variation from an established growth pattern over a period of time suggests the need to evaluate the child further to determine the cause, including in the evaluation an assessment of nutritional intake, biochemical determinations, and general health status.

Although clinical signs of malnutrition have been used to assess nutritional status, it has been found in Guatemala that these signs do not occur in the preschool child with sufficient frequency to be of great value.²² They are of greatest evidence in the very severe cases where no doubt about the existence of malnutrition is any longer possible. In the less severe stages of malnutrition, they are not as frequently found. Moreover, some of the early signs of malnutrition are not specific to malnutrition alone and interpretation of these signs must always be made with the aid of biochemical, anthropometric, and dietary information.

The effect of infectious disease on the malnourished child is also an important consideration in an overall assessment of nutritional status. Full-blown kwashiorkor is frequently triggered by an infectious episode in a child who is living in a state of precarious nutritional balance. When this precarious balance is upset by the added insult of an infectious process, the child can no longer compensate for the chronic nutritional deficits. Moreover, in children with such a precarious nutritional balance, the common childhood diseases like measles and chickenpox bring markedly increased mortality and morbidity. Thus, the synergism, or interplay, between nutrition and infection²³ complicates any prediction regarding the development of the child caught in a complex net of nutri-

tional deficits, poor hygienic conditions, inadequate medical care, and sociocultural patterns that tend to perpetuate such problems.

Some solutions

The most obvious solution to the problem of malnutrition would seem to be to provide food. But this is a markedly oversimplified solution for such a complex problem.

There is, of course, real reason to be concerned about food shortages in many parts of the world. Attempts have been made in the past to provide surplus food from the more prosperous countries to feed the hungry in less prosperous areas. However, such surpluses are dwindling and are not presently adequate to feed all the hungry people in the world. In addition, there is the problem of high costs of transporting such foodstuffs for great distances, losses due to spoilage, and destruction by pests and rodents in transit and in storage. At best, supplying food from other countries is a temporary solution to an increasingly serious problem. Ultimately, it becomes essential for supplemental food supplies to be produced in the areas in which they are consumed. But this measure, of course, does not solve the problem of malnutrition in prosperous countries like our own where nutritious foods are abundant.

In the prosperous industrial nations, foods containing protein of high biological value come primarily from animal sources. Since abundant animal protein products are not available in developing countries, mixtures of plant proteins are being investigated as possible substitutes. Various mixtures of plant proteins of high biological value have already been utilized in some parts of the world. Seafood products are also being investigated as a source of needed protein. It will take time to evaluate the adequacy of such dietary supplements for inducing acceptable growth and development in infants and young children.

It has long been known that if a food supplement is to be successful in nourishing a malnourished population, it must be acceptable to the people for whom it is intended. Changing food fads and habits even in malnourished populations is extremely difficult. Therefore, nutrition education is of the utmost importance to any nutrition program, whether in the United States or in other countries. Economic problems also have to be reckoned with as high cost food supplements could not be purchased by low-income families, the greatest victims of malnutrition.

Malnutrition is now recognized as a major factor in childhood morbidity and mortality, as well as growth failure, wherever poverty exists. However, any attack on this problem to be successful must also include an attack on related sociocultural problems, especially the problem of psychosocial deprivation in early life. Dynamic nutritional programs are certainly needed both in our own country and in other countries. But the search for more knowledge about malnutrition and its effects must go on if malnutrition is to be prevented and corrected. Information gained from investigations in developing countries, as in the Guatemalan studies, have implications for the improvement of nutritional status as important for children in the United States as for children elsewhere.

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. . . And so social scientists or political scientists have got to be very careful; the legitimate inquiries they make as scholars can be used by any number of unscrupulous politicians and their followers to justify otherwise unconscionable delays, to support the formation of studies or commissions whose purposes are sometimes clear indeed: deflect what sentiment for *action* remains, appease what lingering outrage or shame persists, preserve "things" altogether, or give only the slightest ground, and in general postpone rather than encourage changes, no matter how urgently needed by millions of men, women, and children.

Robert Coles, "Still Hungry in America," *The New American Library, Inc.*, in association with *The World Publishing Co.*, Cleveland, Ohio, 1969.

COMMUNICATING with TODAY'S TEENAGERS

..... an Exercise between Generations

EVA SCHINDLER-RAINMAN

● In a world so technologically advanced that we can send men to the moon and talk with them while they are there, it is both amazing and terrifying to realize that we do not communicate well with each other here on earth. Countries are divided from each other, people within countries are fighting with each other, the young confront their elders, and the elders condemn the actions of the young.

As John Gardner has said, this is a time for self-renewal of the society.¹ Renewal through intergenerational dialogue can perhaps contribute both inspiration and methods for this kind of effort. As a small beginning in breaking down the communication barriers between the generations, the author of this article during this past year has designed and conducted a series of "happenings" to bring young people and adults together to look at their mutual resources and problems. These happenings have been based on the following assumptions:

1. A serious problem facing our society is the lack of communication between the generations.
2. There are a number of generation gaps. They exist between middle-aged persons ("middlers") and their elders, between "middlers" and "youngers," and of course also between "elders" and "youngers."
3. People in the helping professions have little or no real understanding of the generation gaps and little or no skills in narrowing the gaps.

4. The gaps can be narrowed through intergenerational dialogue, understanding, confrontation, and the sharing of experiences.

5. All participants, regardless of age, bring unique ideas, ideals, and resources to a group learning experience.

These assumptions were tested in two conference-happenings—"The Generation Mix," sponsored by the Jewish Family Service of Los Angeles in December 1968, and "The Dialogue of the Ages," sponsored by the National Assembly for Social Policy and Development, in New York City in May 1969. The assumptions were given a more comprehensive airing in a 1-week course-happening—"Communicating With Today's Teenagers"—at the University of California at Irvine in August 1969, which is described in this article. Designed for teachers, parents, social workers, librarians, public health nurses, and other people interested in intergenerational dialogue, the course-happening was set up as a seminar, with the author as instructor. About 40 adults were expected, but 185 enrolled—176 for 2 hours of credit. In addition, 30 teenagers were recruited to participate in the discussions and demonstrations.

The purpose of this "course-happening" was to provide the participants an opportunity—

- To look at themselves and others of different generations and to pioneer in developing new directions for communication.

- To think; to try new patterns of behavior; and to learn about new ideas and trends.

- To use all the resources both “youngers” and “elders” brought to the course.

The course-happening began with a review of recent trends toward change in the United States—intergenerational gaps, racial problems, new employment patterns, new family patterns, increasing mobility, new sexual mores, drug usage, and health problems, such as birth defects and the various forms of heart disease.

Self-inquiry

The participants were then asked to think and write individually about the following statements:

1. These things I hold near and dear
2. These things I am not so sure about
3. These things I would never change my mind about

Without talking to his neighbor, each person filled out a self-inquiry sheet, listing his thoughts under each of the three headings. The exercise was revealing. For example, at the end of the course, a 12th-grade teacher wrote:

I followed my instructor's directions . . . to list the “things you hold near and dear.” My list was my God, my family, my health, nature, books, myself, and memories. Then it was that the moment of truth arrived. As I read the list, I saw not the person I thought I was, but someone very different. I knew I loved all those things. I had always thought of myself as a teacher who loved students, but lo and behold, teaching was not included in my list and neither were my students.

Among the things held “near and dear,” the adults mentioned the following: family; formal institutionalized religion; personal and material security; success in a chosen profession; ability to communicate; future goals, or “making it” at some time, some place, somewhere in the future; helping others; making money; doing things for a reason; and physical health.

The teenagers, on the other hand, mentioned self-love—which they described as oneself and his own interests always coming first. A 16-year-old boy explained, “The first thing you have to do is ‘love yourself’ and after that you can love somebody else.” In response to an adult who challenged this value, the boy added: “It is probably true that one does not develop true love of self until one is a little older.”

A girl asked, “But why can't you love yourself on the way?”

Another thing that teenagers considered “near and dear” was time, “the essence of life.” One girl commented, “Every moment is important and you should utilize it to the hilt.” The teenagers also listed freedom to be oneself and to express oneself; physical health, because “all you have is yourself and you'd better take good care of yourself”; faith in something bigger than oneself, but not an institutionalized God; communication—including silence and nonverbal and verbal communication; appreciating life in the here-and-now, as opposed to adults who worry about tomorrow; finding a way of life; and morality, which was defined as doing “what you yourself think is right.” “Everything that we do does not have to have a goal,” the teenagers said. “After all, helping others is also helping yourself.”

Under things that they were not sure about, adults listed religion, honesty and openness, the draft, and sex. Teenagers listed the value of formal education, sexual taboos, the draft, and formal religion. Formal religion, said one, “is just too commercialized.”

Among the things they would never change their minds about, adults listed relations to their families, religious beliefs, love of country, disapproval of long hair on boys, and honesty in dealing with others. The young people listed their freedom, their right to try any experience, and their right to make their own decisions.

After making their lists, the 215 people were divided into 15 groups and moved to separate rooms to discuss what they had listed. Two teenagers were assigned to each group.

After the group sessions, a general meeting was held, at which the teenagers were asked to sit on the edge of the stage if they wished and join in the discussion of the adults' reports. There followed the first real communication between the generations.

Eva Schindler-Rainman, a free lance consultant in the behavioral sciences, conducted the course-happening at the University of California-Irvine she describes in her article. She also conducts seminars and special workshops at a number of other universities and provides consultation to national health, education, welfare, and recreational organizations, as well as to industrial groups. She received her Ph. D. in psychology from the University of Southern California.



"How can we encourage you?" asked the parents and teachers.

"Let us go our own way," answered the young people.

"How can we respect you, without copying you?"

"My teacher is cool; she is three-dimensional. She has a lot on her own; she loves kids; and she really has a groovy classroom."

Parents: "What if we find marijuana hidden in your room?" Teenager: "Sit down and talk about it with us."

"I want to change the United States because I like it."

"Change happens through change in self and then one is able to influence others."

"We've decided all that's hanging us up is people."

"Education could be a great thing; the high school could be a center for learning—but it isn't."

Role-playing techniques

At the next session, participants formed small groups to engage in brainstorming and role playing. After discussing the kinds of "hang ups" they had had with people of other generations, each group picked one problem to dramatize.

The instructor led one group in a demonstration of how to play out its particular "hang up." The actors included a teenage daughter who wanted to see the play "Hair," a father who disapproved, and a mother, caught between the father and the daughter, who was unable to make up her mind. In this role-playing situation, the instructor asked an adult to play the role of the teenager and a teenager to play the role of each adult. Behind each actor a monitor was stationed to keep the role playing realistic. For example, a teenager stood behind the adult playing the teenager, a man stood behind the girl playing the father, and a woman stood behind the boy playing the mother. The scene was played with several "stop-action" periods, in which the instructor discussed the problem and the monitors coached the actors. Then audience participation was invited. Using suggestions from the audience, the actors replayed the scene to demonstrate alternative ways of handling the situation. From this role playing, the audience learned that—

- Members of a family need time to learn to communicate with each other.

- Parents do not always need to agree, but they do need to be open and honest with their children.

- It is hard to listen to another person without looking at him.

- Both parents and teenagers need to be open-minded enough to be able to alter their ideas, stances, and opinions after discussion.

- It is all right to agree to disagree.

- It is important for members of a family to try to understand each other's world, even if they do not have the same points of view.

- Parents need to know what teenagers are really asking before setting rules for an activity.

- Conflict can be utilized productively.

The second day began with a brainstorming session on how to increase understanding between the generations. Divided into small groups, the participants were asked to think of ways to narrow the generation gaps. The suggestions called for members of both generations to learn to listen to each other; to try not to prejudge a person or situation; to "keep the lid off if you have to put people in boxes" to classify them; to work together on a creative compromise when neither the young nor the old have the answer; to put young people as voting members on decisionmaking bodies, such as boards of education; to encourage a broad spectrum of life styles, values, and mores.

The participants were then divided into the original groupings and returned to small rooms. Each group selected an intergenerational "hang up" to dramatize and appointed two observers to direct the role playing, keep the discussion moving, and record some of the ideas. Teenagers played the roles of adults, adults played teenagers, men played women, and women played men.

The 15 dramatizations included, among others, the following situations: the parents of a teenage boy were called to the high school after "pot" was found in his locker; a girl went to a Friday evening party and did not come home until early Monday morning; a girl's parents objected to her dating an older boy of another race; and a pregnant teenage girl did not want to marry her boy friend.

Such role playing helped the adults become aware of the "binds" that today's teenagers get into with their increased freedom of movement, opportunities for sexual relations, and easy access to drugs, and the teenagers' genuine need for understanding from, control by, and communication with adults.

The next activity divided the 215 participants into

trios. They were told to pretend they were in a helicopter in January 1970. The adults were asked, "As you look down on your school, your health center, your library, or your home, what would make you happy about your relationship with one teenager or group of teenagers?" The teenagers were asked, "What would make you happy in January 1970 about your relationship with an important adult?"

Members of each trio helped each other probe deeper into and get more specific about the "images of potential" they had projected. Each trio selected one image to work on and outlined specific steps for action to realize it.

Alienation

On the third day, a consultant, Frances Heussenstamm, a sociologist from the California State College, Los Angeles, helped the participants look at the problem of alienated youth. The chief cause of young people's alienation from society, she said, is the paradox in society's preachments and practices. She delineated characteristics of alienation as powerlessness, normlessness, meaninglessness, social isolation, and estrangement from self. For each of these characteristics, she played tape recordings of a number of rock songs that express the feelings of today's young people, such as "What's Wrong?," "Happiness Is a Warm Gun," "The American Metaphysical Circus," and "Stand!". Other songs expressed young

people's feelings about various aspects of the social scene: poverty, racism, materialism, hypocrisy, pretense in interpersonal relations, irrelevance of education, and police brutality. Dr. Heussenstamm distributed a 17-page song sheet so that the audience could follow the words while listening to the music.

Participants formed new groups to discuss the feelings they had as they became aware of the meaning of the words of the songs while the music was playing and the implications of this experience on the adults' understanding of teenagers. Then, in a "talk-back" session, they reported on their discussions. They asked Dr. Heussenstamm such questions as "Do kids really listen to the words?" "Do they really like these songs?" "Do they really believe what the words say?" "How did middle-class kids get this way anyway?" "Is rock music drug oriented?"

Later, sheets were distributed that contained the words and music of six songs written by young people for a Catholic folk Mass. While the language differed from the protest songs, the Mass songs clearly expressed the desire for identity, the need to dream, the need for belief, and the need for one another. The theme of freedom came through in both types of songs.

An exciting conversation between the instructor and 14 teenagers gave the audience a chance to listen to the young people's points of view and to ask questions. It was amazingly easy to recruit the participants. Boys and girls, blacks and whites, came from

Teenage participants react to reports of small discussion groups in a "course-happening" on intergenerational communication.



the audience and joined the instructor on the stage. These young people held a wide range of opinions about this country, their schools, and their parents—from acceptance of the status quo to a belief in the need for total revolution. One militant teenager said, "We will have to shoot most of you before we are going to get any change." The instructor began the conversation by asking the young people:

What could adults do to make life better for you?

The teenagers' comments included:

Adults could show us they care.

Parents need to care.

Parents need to understand that kids want to do things on their own.

Love is more important than money.

Authoritarian directions just squash us.

Why not tell us what the rules are for or ask us to help make the rules?

Parents should live what they tell us to do.

Why are parents always running around earning money when they should be around with their kids?

Then the instructor asked:

What could turn you on about education?

The teenagers suggested that teachers "come out from behind the desk and become more human" so that students could know them as persons; that students participate in some of the decisions in relation to the way schools are run; that high school education be made to seem relevant to young people with courses on psychology and on the urban crisis.

When asked how home discipline could be more supportive, a teenager replied that parents who are not hypocritical are good models and that a family council could establish the kind of rules that make it possible for a family to function. One youngster said, "My parents have taught me to trust and to respect myself." Another pointed out that it is important for young people's parents to "stick to what they really believe."

This teenager-adult conversation was scheduled for only 1 hour. Because it was obviously not finished when the hour ended the instructor asked the teenagers if they wanted to continue. The young people, who described their participation as "a gift of love" to the adults, suggested that the adults decide. The vote to continue was almost unanimous, and the con-

versation went on for another hour. After it ended, each group of eight adult participants was joined by at least one teenager. The group members then spent an hour discussing the points that the teenagers had made.

In a meeting of the entire seminar, the participants discussed what they had learned and the ideas they would be taking home. Most frequently cited was a recognition that "it is all right for differences to exist." Said one participant, "We can probably cope with differences as long as we understand why they exist." For example, communication about the difference between the future-goal orientation of adults and the here-and-now orientation of young people might lead to acceptance by both groups. Participants said they learned that unless adults "really listen," they usually react defensively when their ideas, values, and goals are questioned.

Coping with conflict

After a lecture on conflict by the instructor, the participants divided into small groups to look at the real difficulties in coping with conflict and to find ways of using conflict productively and creatively. Members of one of the 15 groups regarded conflict as "so terrible" that they were unable to talk about even the positive aspects of coping with it or using it creatively.

The other groups, however, suggested a number of mechanisms for coping with conflict: flight; lying; forms of escape such as alcohol, cigarettes, and drugs; psychosomatic illness; sublimation; shouting; rejection; defensiveness; desertion; and referring the problem to a committee. Suggestions for coping constructively with conflict included calling on a third-party mediator, fractionalizing the conflict into parts that could be handled, and making a clear statement of differences as well as areas of agreement and coming to a compromise. It was pointed out that when people really listen to one another, they can often use all of the ideas that have been proposed in reaching a positive compromise.

The 176 participants who were taking the course for credit wrote a paper on what they had learned or what they might do differently as a result of their exposures in this course.

One participant wrote:

I considered myself a very understanding person and teacher, open to new ideas and able to accept my students for what they are. . . . After my experience here, I fully realize how wrong I was. I need to sit back and to take a look at myself before I can really communicate with others.

A junior high school teacher said he had enrolled in the course to discover how to improve his chances of communicating with today's "disrespectful, irresponsible teenagers." About the middle of the course it became obvious to him that he had not been open with his students. He commented: "I now know that what I really have to worry about is how to communicate with today's adults and help them communicate better with today's resourceful and fine teenagers."

Among other reactions:

I came to this class to try to understand just what is going on with today's youth and how better I can cope with it. I leave it much more concerned with just what is going on with today's adults, myself in particular, and how the young person can be helped to cope with it.

I feel strongly that most problem kids are really the product of problem adults.

I found that I did not have enough confidence in the student's own ability to make good decisions. I did too much of the work myself and did not involve them enough.

In a final lecture, "Tune In On—Or Turn On To—Intergenerational Communication," the instructor emphasized the need for continuing conversation between young people and adults. She summarized the blocks to intergenerational communication that the participants had identified and the resources avail-

able for surmounting them. Among the major blocks identified had been the lack of mutual trust and the disappointment about life felt by many adults and some young people. Among the methods that had been identified for improving communication between the generations were: taking time to build relationships of trust and communication; being available to help others; involving students as well as teachers and administrators in planning school curriculum; checking assumptions before making a judgment that boxes in another person; and being willing to be exposed to new ideas and patterns of behavior.

Effective intergenerational dialogue, the participants learned, requires persons of all ages—

- To be willing to listen and to hear.
- To guide, but not to goad, others.
- To be open-minded.
- To be innovative rather than imitative.
- To act rather than to react.
- To care enough to try.

¹ Gardner, John: Toward a self-renewing society. *Time*, April 11, 1969.

WHAT DO YOUNG PEOPLE WANT?

CATHARINE V. RICHARDS

● Although it would be convenient and impressive to capture in a capsule the hopes of young people, it is no more possible to do this than to identify what adults want. But some things seem eminently clear, even in the unsettled turbulence of these troubled times. Young people do want to be autonomous, and they do want to maintain their integrity. Young people do want to be included in the life of society, not in the nurturing sense as children, but as persons recognized as capable of managing

their lives and of contributing creatively to the development of the community.

As Piri Thomas pleaded so eloquently in a workshop called "Identity in a Troubled Time":

Tell us, are you sort of digging us kids all the way? Well, don't. We're older than you think, inside where you don't see, where you don't feel or hardly understand.¹

Over and over again, it comes through loud and clear that young people want to be regarded as in-

dividuals, as persons in their own right and not as a category of human beings.

Unfortunately, the terms "youth" and the more inclusive "young people" usually designate a period in life when society ceases to regard the person as a child, but does not accord the person status, roles, or functions as an adult. As Erik Erikson has noted:

Youth shares with other groups, such as women and old people, the fact that the role assigned to it by nature has been elaborated by cultures as a set of differences from some standard human being, the norm, of course, being usually the normal adult male. The group is then judged on the basis of what it is not and will never be, or is not quite yet, or is not any more.²

More precisely, this transition between childhood and adult status generally begins at about 10 years of age for girls and at 11 for boys. The physiological development occurring about this time usually is accompanied by new and increased awareness of self and others. For healthy young people, this step intensifies the continuing quest for autonomy—the search to be self-propelled, to manage oneself and the situations encountered in living.

Basically, by the age of 13 to 15, young people have the capacity to cope with their environment. But they lack the experience essential for developing the judgment necessary to negotiate with complex, urban living. Thus, there is heard the repetitive cry for an education that is "relevant."

A limited number of young people may be treated by others as adults when they are 14 or 15 years of age. But in most instances the cutoff point marking adult status ranges from the age of 17 or 18, when many State laws sanction employment, to 22 or 24, when young men or women conclude their higher education and enter the labor force or establish families.

Relevant questions

It may be that the recurring question "What do young people want?" is not the right question. Perhaps what is more relevant for a democratic society are the questions: "How can we (adults and young people) be most helpful to each other?" "How can we assure each person increasing opportunity to develop as an individual and as an active participant in a democracy?"

These questions are as old as this Nation. Of particular relevance for today is the related question: "Are we willing to pay the price for living in a democracy in terms of caring, sharing, personal discipline, and the other heavy costs exacted of those who

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are participating members?" Possibly this is what some young adults are wanting for themselves and others. For out of the garbled communication from the disenchanted, dissident, and protesting young adults may be heard the sharp criticism of a society that will tolerate injustices, inequities, and indifference to human well-being.

Musgrove in his closely reasoned "Youth and the Social Order"³ describes the situation and proposes some ways of managing the problem:

The reintegration of students with society is an urgent need not only for their own sanity and mature development (and proper sense of social values), but for their greater effectiveness when they eventually take up their careers. The unreality of contemporary student life, its apartness, its lack of immediate social relevance and sense of usefully contributing to the Nation's concerns are causes of stress and conflict, which can without great difficulty and even with considerable economy be eradicated.³

Musgrove is stating the case for college and university students. An equally strong appeal can be made for the developmental needs of young persons 13 or 14 years of age. They should have the choice of alternative, equivalent routes to adult status. Such routes might well include the work-study programs that are now available for selected older students who have attained prescribed grade or dropout status. Conceivably, there could be volunteer work-study programs on various time schedules as well as more educational exchange programs. The exchange programs would provide young people experiences with travel, with people of difference in diverse sections of the Nation, and with managing themselves as individuals and as contributing members of the communities in which they would be studying.

The younger members of what is referred to as "youth" are not unaware of the frequent gaps between our Nation's ideals and its actions. But they are economically less free and physically more dependent than the older ones. These young people of 10 to 16 years of age are too often relegated to the

periphery of community life and are frequently locked into a mass production system of education. Some of them manage this socializing interval with equanimity and zest; some endure it at great personal cost; and some refuse in various ways to accept the established process.

Young people's views

These young people assess life about them. When given the chance to air their views, they are perceptive, poignant, and provocative.

In a conversation concerned with "identity in a troubled time," a recent high school graduate about to enter college observed: "We don't understand what the hell can be wrong, because everything is so great for us in some ways." This point of view is echoed by other young people, but there are those who shade their observations with more certainty and cynicism.¹

For example, a 17-year-old girl in the Midwest, when asked to describe problems of young people, wrote:

. . . The kids are too sensitive to take the "be good Johnnys" . . . that the shallow parents dish out. They don't know what they want to do. They are smart enough so that they can see how ugly the trash, the "technological advances," and the "make the world safe for democracy" propaganda is. . . .

This would not all be so rebellious, blatant, or futile if people loved and understood one another more. But they don't . . . so what's the use of wanting? I don't see where the world's going to be a better place just because we can now squeeze our oranges electronically.

And I don't see what you can do about it. But maybe you can. Good luck!¹

The voices of the reflective young people of college age are frequently lost in the strident noise of dissidence, demonstration, and protest. But the vast majority of the young adults manage to deal with the profusion of options and the confusions and pressures of this technocratic era with vigor, daring, and the willingness to question the purpose, the meaning, and the values that define life about them.

These many voices say in very distinct and diverse ways: "I am trying to be me. I am hard at work being the unique someone of worth that I am in a world that does not measure up to the promise of what I think it could be."

As the quotations cited illustrate, among the young there are those who are willing to search for answers

and to tackle the problems with which they are confronted; some choose to run away and to leave to others the task of shaping a better life for people.

Still others among the young adults are willing to risk themselves in challenging the centers of power to try to effect a redistribution of powers. On and off campus, these struggles engage the energies and hopes of some and the empathetic response of young people. Challenges to centers of power usually generate crises, and occasionally erupt in violence. Violence is a very dangerous counter-productive instrument. At its worst, it destroys those who would use it to destroy others, social institutions, or ideas.

Challenges to the centers of power, to the national priorities, and to social arrangements reflect the young people's response to the world as they see it. Many young people are impatient and eager for action that will right the wrongs as they see them. Some few become the foils for persons who use the discontented, the problem-ridden, or the naive for political or personal gain.

Generally, this young population is overloading the established order with demands for change. They have learned that a democracy is supposed to be self-renewing and self-transforming in response to the changing conditions of the social order. But arranging the social resources to meet the urgent demands of changing views of what is possible is taxing the ingenuity and the capacities of young and old.

What do young people want? Their many voices send out varied cryptic messages. Although concerned adults may try to decode these messages for clues to what young people want, they represent only a fraction of what the situation demands today. If young people are to be autonomous persons with integrity who are cherished contributors to the development of community life, the time has come for adults to put themselves on the line as partners in action for communities worthy of the potentials of man—both the young and the not so young.

¹U.S. Department of Health, Education, and Welfare, Social and Rehabilitation Service, Children's Bureau: *Identity in a troubled world.* (In press.)

²Erikson, E. H.: *Youth: change and challenge.* Basic Books, New York, N.Y. 1963.

³Musgrove, F.: *Youth and the social order,* Indiana University Press, Bloomington, Ind. 1965.

FAMILY TIES

and the

INSTITUTIONAL

CHILD

MARGRIT MEYER

● All children need family ties. They need them whether or not they are able to live in their own families. And for this reason, child-placing agencies during these last few decades have strengthened their work with parents and relatives while children are being placed in adoptive homes, foster homes, group homes, and child-caring institutions. Some parents have been helped to resume full-time care of their children. But, unfortunately, some parents have been unable, even with agency help, to maintain even a minimum role in the lives of their children. Some of these children are placed in adoptive homes; some find a supportive foster family. But others arrive at the doors of child-caring institutions with practically no ties to adults meaningful to them.

If a separation of the child from his family takes place abruptly and work with the family in behalf of the child ceases at that point, the chances for the child's eventual reunion with his parents may be lost. Moreover, the child's ability to develop new family ties may also be severely impaired. Even for such children, however, an institutional placement need not be the end of a family relationship. Some children may be helped finally to recognize that their parents or relatives will never be able to provide a home for them and so may eventually be able to accept a substitute family. Even those children too hurt from past experiences to be able to accept the close relationship required in family living may be helped to

develop a certain sense of family belonging through opportunities to visit part-time foster families or to keep in touch with brothers and sisters or others with whom they have had meaningful relationships.

The foregoing observations are based on experiences with children at the Cunningham Children's Home, a church-related institution for emotionally disturbed school-age children in Urbana, Ill., that has a capacity of 52 children and adolescents, 10 of whom live in two small group homes for teenagers. Cunningham accepts children from the public welfare department and from voluntary child-placing agencies, including many who have been committed to the care of these agencies because of parental neglect. However, it only takes children from any source who are well enough to attend the local public schools.

In contrast to the population of most other child-caring institutions, 80 percent of the children admitted to Cunningham are of high-school age, and most of these remain until they finish high school. Only about 10 percent of those admitted each year are ever returned to the care of their own parents. Five percent leave the institution to go into foster homes obtained by the institution. These are usually younger children.

Some practical advice

On the basis of experiences with children placed in Cunningham, I would advise placement agencies or, if necessary, institutions to carry out the following procedures *when at all possible*:

1. *Involve the child and both his parents in the pre-placement planning* through family interviews that are focused on the need for placement.

This should be the responsibility of the placing agency.

The casework staff at Cunningham is ready to assert almost unequivocally that the greater the degree of the child's and family's involvement in the preplacement and placement planning, the more likely he is to accept the separation from his family, the less resentful he will be of the placement, and the less need he will have to produce grandiose fantasies about his family. Others have made similar observations.^{1, 2}

Betty B, a Cunningham child, provides a poignant example of the destructiveness of abruptly separating a child from his parents.

When Betty was 6 years old, she and her brothers and sisters were suddenly removed from their par-

ents because of inadequate care. The children were at the same time separated from each other. Some were placed in institutions and some, including Betty, in separate foster homes. Betty came to Cunningham at the age of 10 after having failed to adjust to four successive foster homes. She did better in the institution, but as her behavior improved, she began telling stories around the campus about what had happened to her parents: they had died in an automobile accident; they had been killed in a fire. She also told tales about the fun the family had had together.

Recognizing the necessity of helping Betty face reality, her caseworker encouraged her to remember and accept the past. Gradually, Betty was able to recall the dirty, ill-kept home, her parents' heavy drinking, and the abuse to which her father had subjected her mother. Nevertheless, she wanted desperately to see her parents again. When the placing agency reported having lost track of them, Betty said to her caseworker at Cunningham, "If I can't have my own family, find me another one."

The institution did find potential foster parents for Betty, and after she had visited them regularly on weekends for several months, she was moved into their home for full-time care. She adjusted well at first, but after a while she again began to tell fanciful stories about her own parents. The security of having a home of her own seemed to give her a sense of guilt at having abandoned her own family.

Convinced that Betty would not be able to accept surrogate parents until she came to a realistic assessment of what her own parents could or could not offer her, the institution then attempted to find Betty's parents, and did so. Regular visiting between Betty and her own family followed for awhile. Unfortunately, by the time Betty began to see that her own parents could never provide her with a suitable home, the foster family had become too afraid of her emotional problems to reaccept her into their home on other than a visiting basis.

It cannot be said with certainty that Betty's life would have taken a markedly different turn had she been better prepared for the separation from her parents and been given greater support in the subsequent months; but it seems very likely that under such circumstances she would have suffered less trauma and adjusted better to foster care.

2. *Request parents to go on the preplacement visit to the institution* with the child and the agency worker. If a parent refuses to do so, help the child see that it is the parent's refusal, not the agency's prohibition, that accounts for the parent's absence.

3. *After the placement, schedule family conferences regularly*, involving parents and all the children in the family, including the placed child.

These conferences can bring the institutional caseworker an understanding of the needs of the individual family members so that he can help them to greater self-awareness and can support their efforts to strengthen areas of weakness.

After a series of such family conferences, Cunningham has been able to return a teenage girl to a once seriously disorganized family, for the mother has become more outgoing, the father has become more aware of his own shortcomings as a father and a husband, and all concerned have determined to carry out their family responsibilities more adequately.

Another family group, through family conferences, has come to recognize the intractability of one of its members as an insurmountable block to the child's returning home permanently. The important point: the family, not the agency or worker, made this clear to the child.

4. *Permit the child to visit his family* at his request unless this is denied him by the family.

Such visits of course will precipitate behavior problems, and these will need to be discussed with the child and the adults involved—houseparents, foster parents, caseworkers, and the child's parents. The child's houseparents, or his foster parents, as the case may be, may especially need help in understanding the importance of the visit home and the meaning of the child's disruptive behavior afterward.

Another example of how a visit home can help children reach a real understanding of why they cannot live at home is provided by Mary, a highly disturbed teenage girl, who had little preparation for her placement in Cunningham. On the theory that a visit home would only upset Mary more, the institution at first denied her repeated requests for per-

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mission to go home to see her parents. However, her behavior deteriorated, and eventually the institution and the placement agency agreed that little could be lost by granting Mary's request.

Mary went home for a weekend, and since then her attitude toward the institution and its staff has changed. No longer is it, "You people are too mean to let me go home." Now it is, "I'm really treated with more concern here than at home. But I'm still unhappy. What can I do about myself?"

Mary is still an agitated, disturbed youngster, but with the help of her caseworker she is growing in self-knowledge and self-awareness. We are confident she will eventually change her behavior.

5. If the family refuses to have the child at home, see that the family makes this clear to the child in a direct confrontation when the child is ready for it. Such a confrontation helps the child face reality.

This proved true in the case of John, an adopted child who came to Cunningham at the age of 14. John had been treated like a pampered pet until he was 6 years old when his adoptive mother gave birth to a baby and suddenly found she no longer needed him. From then on he was at best only tolerated, and as a result he developed behavior problems, which led to his placement at Cunningham. It took years for John to accept the fact that his mother had permanently rejected him. He developed a fantasy that if only he behaved in an acceptable way at Cunningham and on his visits home he would be reaccepted by his family.

Following are some excerpts from the institutional caseworker's record:

The family continues to play the all-important role in John's life. They visit him here; he has visited home four times since summer's end. The dramatic thing in these visits has been their lack of drama—John has done well, no fireworks.

John's father has admitted to me that his wife will leave him and take Peter if he pushes her about John. He feels inadequate and tied. He knows she would like to disinherit John.

All of this crystallized in the post-Christmas meeting with me when for the first time the mother said she did not want John at home, and that she knew we all thought it was her fault. The father neither supported her nor fought her. Silence. . . .

And then 10 months later—

There have been no significant changes in anyone or in their relationships. Visiting here was fairly regular until the strike when the family excused themselves because of a pinched budget and difficulty in planning because of the father's odd jobs. The father was planning on having John home during his own summer vacation but because of the strike he never had one. . . .

John vacillates. He wants to go home to stay, he doesn't; he

wants to have his parents, he doesn't. At the bottom of all of this is his desire to have them full time or to expel them from his life—but this is too frightening.

He has gone so far as to demand that they have him home or sign permission for him to enter the Army. Then he will go to Vietnam, make sure he is shot, and they will have murdered him. During this period, the mother was forced by John and the worker to tell him that she did not think she could ever have him home again except for visits.

For several weeks after this entry, John acted out his despair in recurring episodes of disturbing behavior. But gradually he learned to accept his mother's rejection and his father's inability to take a stand in his behalf. Now he thinks of Cunningham as his home, the place where he will stay until he finishes high school. He is no longer involved in destructive activities and is making an obvious effort to contribute positively to the lives of those around him.

6. Place all the children from the same family needing care away from home in the same foster home or institution, unless their being together is diagnostically contraindicated by the quality of their relationship—as in cases of incest or intense sibling rivalry. With such exceptions, Cunningham gives priority in its admission policy to sibling groups out of a conviction that brothers and sisters can derive strength from each other and so make better use of the institution. When the siblings are of the same sex, they are assigned to the same cottage unless they have problems making this inadvisable; but even when living in different cottages, they are given daily opportunities to be together.

7. Arrange visits with siblings for the child whose family has become completely broken apart and separated and who needs to keep in touch with his brothers and sisters or get to know them.

8. Schedule followup family interviews with a caseworker on a regular basis for as long as needed after the child's return home or placement in a foster family.

Such interviews are important in helping the child and the family readjust to one another.

9. Stand by as a continuing resource for the child and the family after regular contacts have ceased.

At Cunningham, we believe that the task of assessing family problems and strengths is best carried out by the agency that is working directly with the child, provided the agency's distance from the family is not so great as to constitute a problem. In most instances, this places responsibility on the institu-

tional caseworker for working with the child's family while the child is in the institution. Again it seems logical for the institutional worker who has built up a relationship of trust with the child to be the one to carry on the followup family interviews.

Even in instances in which a court order has given the placement agency legal responsibility for the child, the institutional worker is likely to have the closest relationship to the child and, therefore, to be the most logical person to work with the family while the child is in placement or afterward. We have found at Cunningham that agencies that have tried unsuccessfully to work with the families of our children are often willing to have the institutional worker take this responsibility and will make written agreements with the institution to this effect.

Foster families

However, as already mentioned, only a small percentage of children admitted to Cunningham ever do return to their own families. Many of them have no intact homes to which to return because their parents have disappeared, continue to live in a disorganized fashion, or, having changed marriage partners, have no room for them in their lives. Moreover, many children by the time they reach Cunningham have already failed to adjust to a series of foster homes. Having repeatedly experienced bitter failure, they now expect it and frequently provoke it. Must these children then look forward to a childhood spent in an institution as the only alternative to another failure in a foster home?

Cunningham cannot accept this alternative, particularly for its younger children. It has, therefore, devised a plan for the gradual placement of children in foster family homes selected and supervised by the institution with a permanent living plan in view.

When a younger child enters Cunningham, the institution asks the placing agency's permission to seek a family that might provide the child with a weekend home and perhaps eventually a permanent foster home if this seems to be a sound plan for the child. Without exception, the placing agencies, relieved to be free of this responsibility, have signed agreements allowing the institution to assume it, providing the two agencies consult together when changes take place in the long-range plans for the child. The arrangement derives from the assumption that the agency that observes the child daily is best equipped to find the kind of family that will meet his needs.

Each couple that comes to the institution asking for a visiting child is interviewed by a caseworker with the view of assessing the couple's potentiality for providing a child with a permanent foster home. If the couple seems to have this potential, the caseworker asks the husband and wife what they would do if they and the child became attached to one another after several visits together. If they reply that they could make room for one more in their family, the caseworker begins a discussion of the problems associated with foster care: the remaining ties between the child and his own family; the problems that arise when the child comes from a very different kind of background from the foster family's; the emotional problems that the child carries over from his past. The caseworker then asks whether there is anything in the couple's experience to indicate that they might be able to cope with an emotionally deprived child.

The caseworker also explains the problem of children in permanent care whose parents retain parental rights. If a couple fears committing themselves to a child who may never legally be theirs, only children

A teenage boy and a visiting foster family start out from the Cunningham Children's Home for an all-day outing.



who are free for adoption are considered in selecting a child for a visiting arrangement with them. Thus far the primary concern of most couples who have offered to take in Cunningham children has been about what they might be able to give to a child whether or not they could eventually have the child as their own. Fortunately, in instances in which we have found foster families for children who are clamoring for adoption, the foster parents are also very much in favor of it. In these cases the placing agency is taking the necessary steps toward the termination of parental rights.

Visiting relationships

Every eventual foster home placement begins with a visiting relationship. Day-long visits of the child with the family are followed by weekend and vacation visits, often involving trips out of town. The time spent together under a variety of circumstances provides important indications of a family's and child's ability to enjoy one another. Throughout the period of visiting, the caseworker is in regular contact with the visiting family, as well as with the child. Problems are examined and worked through as they arise, sometimes in separate interviews, sometimes with the foster parents and the child together.

If by the time the school year ends the child and family have had regular contact, plans may be made for him to spend the summer months with the family. A vacation spent together can either cement or rift a relationship. In several instances as the summer has drawn to a close, the child or one of the potential foster parents has telephoned to say that they would like to stay together on a permanent basis. When this happens, the caseworker calls a family conference of all the members of the foster family's household, where the implications of making a change in living arrangements are fully discussed. Then, before the child is transferred into the family for full-time care, the agency makes a detailed, formal, foster home study of the family and, if all goes well, obtains permission of the placement agency for transferring the child to the family. This method is similar to one developed by the Astor Children's Home in Rhinebeck, N.Y.³

Each decision to place a child permanently with a family is made in a joint conference with the child, foster parents, caseworker, casework supervisor, and the institution's director. The director is present to impress the family and the child with the seriousness of the commitment they are making. The family

signs a placement agreement in which the word *permanent* appears prominently in the opening sentence.

Since so many people in Champaign-Urbana, Ill., are only temporary residents, the agency has to be prepared on occasion for potential foster families' leaving the area. When this seems imminent, the detailed foster home study is carried out even before the child and family are ready to commit themselves to one another and permission is obtained from the placing agency to allow the child to visit the family during his vacation. The placement agency requests a local agency in the area to which the family has moved to supervise the home. If toward the end of the summer the child and family have not requested a permanent placement, the child returns to Cunningham and another visiting family is sought for him. If he remains with the family, followup supervision is provided by the agency in the area.

For the first few months after a child is placed with a foster family for permanent care, the caseworker continues to have monthly interviews with the family and the child. Gradually, however, the worker sees the family only on request. Cunningham's foster parents, as well as the children in their care, readily turn to the institution for help with problems as they arise. Being mature people, the foster parents are as eager to succeed as the agency is to have them do so and they respond positively to being treated as partners in the development of a venture which, when it began, had so many odds against it that it seemed doomed to failure.

If in the intake interview the applicants for a visiting child indicate they are interested only in a visiting relationship with a Cunningham child and give evidence of having a capacity for developing a relationship with a child that will be meaningful for him, the caseworker suggests that they provide visiting opportunities to an older child who is no longer interested in or able to invest himself in a regular family relationship. In such instances, the caseworker stresses the importance of sticking with the child once a relationship has developed between them. The worker points out that during their first visit with each other the child and adults can gauge their compatibility, and if neither wants to withdraw from the visiting plan at that point, the adults have a responsibility to continue devoting time regularly to the child as long as they remain in the community. Many couples who agree to take on a Cunningham child on a visiting basis are connected with a nearby Air Force base or are students at the local university.

and are therefore only temporary residents of the community. When they leave, we encourage them to maintain contact with the children.

One of our teenagers, Billy, chose his visiting family himself. Having been occasionally picked up by a former Cunningham employee while walking to and from a job he held after school hours, he began to stop at her home for short visits. In that way he met her husband and the two of them found they shared an interest in music. From this common interest a continuing relationship has developed that promises to be a lasting one. This family will never provide Billy with a full-time foster home, but Billy has already failed to adjust in six foster family homes and has no desire to leave the institution.

The caseworkers at Cunningham feel strongly, however, that a younger child should not be encouraged to become involved in a visiting relationship that has no possibility of yielding what he most desires—a family to which he can truly belong—though he may not be fully aware of this desire. They have found that almost as soon as a younger child feels comfortable with a family, he begins to wonder whether the family has become his. This occurs even with children who have said many times that they never want to leave the institution to try another foster family. There is also the danger that the experience of losing a succession of “visiting families” because of changes in the families’ circumstances may aggravate the child’s fear of risking himself in any personal relationships again. Most, if not all, of the relationships that these children have had with adults in the past have ended abruptly.

Continuing relationships

The importance to a child of having a stable, dependable, lasting relationship with an adult cannot be overemphasized. Only through experiencing such a relationship can a child learn to trust other people and so mature emotionally.

In most modern agencies dealing with children, the staff diagnoses the degree of a child’s emotional health and defines his chances for improvement in terms of whether or not he is able to form relationships with other people. “Does he trust people?” is the question asked in staff conferences about a child. If the answer is “no,” learning to trust is set as the treatment goal, and the caseworker, the houseparents, and other staff members expend a great deal of energy helping the child achieve that goal by being for him adults that he can trust.

But what happens when the child or the worker leaves the agency? Usually the child is expected to relinquish the relationship as he has so many others. The professional phrase is, “We’ll help him work through the separation.” Questions are raised about the mental health of the worker if he feels a responsibility to continue a relationship with a child who has learned to trust him, perhaps the first time he has ever trusted anyone. “Why does he need to hang onto this youngster?” the critics ask.

Children’s agencies find it lamentable when a child is unable to form affectional relationships. But what do agencies do over and over again but, through staff changes, manufacture separations that can only once again convince children that human ties inevitably lead to pain? Aware of this problem, Cunningham stresses the importance of enabling young people who are, or have been, in its care to continue their relationships with persons who have played significant roles in their lives if these persons are able and willing to carry on such relationships.

Cunningham regards it as a sign of health that a 16-year-old boy who spent 3 years in the institution wants to return to visit a staff member. The boy’s request indicates that he has developed a sense of trust and ability to relate to others. The continuance of that relationship will make him less wary of assurances that people care about him, for he will see that someone who has cared about him in the past continues to do so.

Cunningham also welcomes the request of one of its teenagers to visit a doctor at a State mental hospital who helped her prepare for life outside the hospital. It understands another child’s attachment to the worker who brought him to Cunningham and his desire to visit with that worker every time he comes to the institution, for it knows that this child needs to feel that the care and interest people have in him are real enough to continue.

When concern is genuine, it does not die at expediency’s command. It is this kind of continuing concern that should be pledged to children by the people whom they have grown to trust with their confidence and affection.

¹ Moss, Sidney: Integration of the family into the child placement process. *Children*, November-December 1968.

² Rose, John: A revelation of the concept of separation for child welfare. *Child Welfare*, December 1962.

³ Naughton, F. X.: Foster home placement as an adjunct to residential treatment. *Social Casework*, June 1957.

RETARDED CHILDREN

at CAMP with NORMAL CHILDREN

NORMAN FLAX

• EDWARD N. PETERS

Early each year, camp administrators are faced with the task of deciding which children should be accepted in their summer programs. Should the blind, the physically handicapped, the diabetic, the emotionally disturbed, or the retarded child be permitted to join other campers in summer recreation? This question concerns the well-being of both normal and handicapped children.

Dr. Alex Rosen has pointed out: "The handicapped person cannot be understood merely by analysis of the functional aspects of the handicap alone. Rather, the community's definition of the handicap influences the self-image and social adjustment of the handicapped person. This internalization takes place as the person becomes aware of this societal definition. Thus deviance is established, reinforced, and internalized."¹

What, then, should social agencies do about the countless number of low-functioning young people who need service?

While administrators of recreation agencies are becoming increasingly sensitive to the leisure-time needs of the handicapped and the possible effects of rejection on young people seeking inclusion in their programs, they must evaluate the possible effects on other campers of including them, as well as on the scope of their programs. Recent experience of the Jewish Community Centers Association of St. Louis, Mo., with mentally retarded campers suggests some possible approaches to decisionmaking in this regard.

Since the summer of 1966, the agency has placed 60 mentally retarded children in summer camp groups, 29 in day camps and 31 in a resident camp. All these children have been diagnosed in the clinical facilities of the St. Louis County Special School Dis-

trict as "educable mentally retarded," which, according to Missouri State laws, required a measured IQ between 48 and 78; and all have attended special school classes for "educable" retarded children. Most of these children have been in the camping program for several years, some for all 4 years. The agency's experience with these children has demonstrated that retarded children can participate with normal children in many activities such as swimming, baseball, camp crafts, folk dancing, singing, and work projects. It has also demonstrated that educable retarded children's behavior characteristics fall well within the range of those exhibited by normal children in groups, and that, on the whole, normal children and their parents do not react negatively to having retarded children in camp.

These findings are the results of careful and systematic analysis of information collected in a demonstration project, known as the EMR Project, which was funded by the National Institute of Mental Health.²

Each year the day camp program serves about 1,000 children between the ages of 6 and 14; the resident camp, Camp Hawthorn, serves approximately 42 children each summer between the ages of 8 and 16. Both camp programs are under the direction and supervision of their regular staff members. The EMR Project has its own staff, which includes four trained social workers and a research psychologist.

Beginning with the fall of 1965, whenever an educable mentally retarded child showed an interest in going to camp, a project social worker interviewed both the mother (father) and the child to gain understanding regarding the child's peer relationships both in school and in the neighborhood, learn about his



One of the divers in this swimming meet is a mentally retarded child. The three other children have normal intelligence.

interests and areas of skill, and obtain information about his handicaps, both visible and hidden. The social worker also reviewed each child's social history, psychological diagnosis, and school experience as noted in the special school records.

Following this intake procedure, the social worker then made a general assessment of the child and attempted to predict the degree of success the child would achieve at camp. Each child was rated on a 1-to-5 scale, which was the worker's judgment of his social readiness. The 5-point scale had the following definitions: (1) unsuited—to be rejected for camp; (2) marginal—could be given camping opportunity only if an especially appropriate group of children could be located for him; (3) a fair risk—probably could obtain at least partial success, but would require a great deal of help; (4) a good risk—probably could succeed in any one of several camp groups; and (5) an excellent risk—likely to find personal satisfaction, likely to be accepted by other campers, and likely to be an asset to group life. Unless judged "unsuited," the child was placed in a group, which in the judgment of the staff, afforded him the best chance for success.

To help the research staff learn how the children performed in their camp groups, each counselor filled out a Group Participation Form on the retarded child in his group. Designed to measure the child's degree of participation in group life, the form in-

cluded 34 items concerned with specific types of behavior in specific situations. Most of the questions had to do with the frequency with which the child behaved in the way described or with the way he behaved most frequently in a particular situation. For example, one question was, "Does this [group] member require frequent and/or continuing reminder of procedures and/or rules?" In answer, the counselor was required to check *always*, *usually*, *sometimes*, *seldom*, or *never*. Another item asked the counselor to check the response that best described the child's most frequent way of contributing to the group's decision about what to do. The form listed five choices for this item:

1. Wanders off from the group during planning.
2. Physically present, but makes no contribution.
3. Contributes suggestions or questions that are usually irrelevant or unrelated.
4. Contributes some relevant suggestions or questions.
5. Takes leadership in suggesting the ideas that are adopted.

Before using the form to assess the group adjustment of the mentally retarded campers, the project requested more than a hundred counselors to use the form to assess the behavior of other children in their groups, selected at random. This precaution was

taken to prevent a characteristic of a retarded child's behavior from being attributed to his retardation when a normal child might exhibit the same type of behavior.

A statistical analysis of these forms indicated that the Group Participation Form was collecting information primarily on three dimensions of a child's participation in the group: (1) the amount of aggressive acting-out behavior exhibited by the child in the group; (2) the extent to which the child seemed to belong to and feel comfortable in the group; and (3) the extent to which the child directed his attention and interaction toward the counselor. Each of these dimensions could be measured for each child by combining the child's scores on pertinent items on the form. The three sets of items selected for this purpose were labeled the Aggressive Acting-Out Scale, the Belongingness and Comfort Scale, and the Leader Orientedness Scale.

The Aggressive Acting-Out Scale assessed the frequency of various kinds of acting-out behavior, such as (1) the extent to which the camper argued and fought with the counselor, (2) how often he became aggressive when faced with derogatory or deflating remarks or with failure, and (3) how much he bragged and boasted, bullied or dominated, disrupted the group, or sought attention. When the measures of these items were combined, the result was a fairly accurate measure of the extent of aggressive acting-out behavior the camper exhibited in the group.

The Belongingness and Comfort Scale assessed the degree of the child's involvement in the group's activities, the extent to which he tended to withdraw from other children, the degree to which other children chose or accepted him, and the degree of comfort he seemed to feel in new or strange group situations. The combined scores on these items measured the degree to which the child had socially adapted or "made it" in the group situation.

The Leader Orientedness Scale was composed of items describing how much the child tended to direct various kinds of interaction and verbalization toward the group leader.

Further statistical analysis has indicated that the three scales are all fairly reliable, consistent measures of uniform, distinct dimensions of children's behavior in groups.

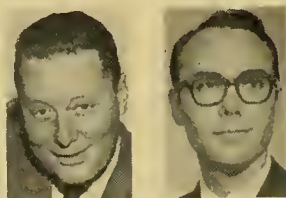
Some findings

Group Participation Forms were collected on every mentally retarded child in a camp group and on a randomly selected normal member in each camp group containing such a child, after the child had spent 1 full day at camp and again at the end of the camp session. The scores on each of the three scales were analyzed to determine if there were any consistent differences, on the average, between the mentally retarded children and the normal group members or if there were any consistent differences, on the average, between the children's behavior early in the camp session and at the completion of camp. These analyses showed no marked differences, on the average, between the retarded and the normal children in the amount of aggressive acting-out behavior or in the amount of leader oriented behavior.

However, the Aggressive Acting-Out Scale showed that all campers, retarded and of normal intelligence, tended to act out more at the end of the camp session than at the very beginning. This will not be a surprise to persons who have ever worked with children in camp groups. However, it does indicate the project's measure of aggressive acting-out behavior is sensitive enough to pick up this difference in an objective, quantifiable manner.

The Belongingness and Comfort Scale showed a distinct difference between the scores of the mentally retarded children and the scores of the children regarded as normal: on the average, the mentally retarded children scored much lower than the other campers. However, while the difference in average scores was large, the scores of the mentally retarded children ranged from a high that is well above the average score of the other campers down to a low that is well below the scores of most of the other campers. Thus, we have an objective and quantified measure of what is already apparent from casual observation of educable mentally retarded children in camp groups—that, in general, these children are not as much at ease as other campers, but there are wide individual differences among them. Some men-

Norman Flax (left) and Dr. Edward N. Peters are both on the staff of the EMR Project at the Jewish Community Centers Association, St. Louis, Mo., described in this article. Mr. Flax is project supervisor, and Dr. Peters is a research psychologist. They are both research associates at Washington University, St. Louis.



tally retarded children do as well in camp groups as many other campers.

That some mentally retarded children can apparently fit well into some groups of normal children makes any blanket policy against placing mentally retarded children into normal camp groups unreasonable. However, some improvement is needed in the ability to predict which mentally retarded children can be integrated into camp groups with normal children with a relatively high degree of success. The Belongingness and Comfort Scale, in providing a relatively sensitive and objective measure of the extent to which a camper adapts socially in his camp group, makes it possible to explore the extent to which various kinds of information are useful for predicting how a mentally retarded child will get along in camp.

The social worker's general assessment of each mentally retarded child who applied for camping, mentioned in the beginning of this article, was an attempt to predict the degree of success each would have in integrating into a camp group on the basis of the information obtained by the social worker during the intake procedure. These predictions, however, were subjective judgments. They did not stand up, under post-camp statistical analysis, as valid predictions of which mentally retarded children would do better than other mentally retarded children in fitting into a camp group.

However, in addition to giving a general assessment or "global prediction" for each mentally retarded child, the social worker rated each child on 40 characteristics from information obtained in the intake procedure. Of these 40 characteristics, eight have turned out to be related to the success of the educable mentally retarded children in camp groups as measured by the Belongingness and Comfort Scale, and the social worker's rating on them to be much closer to a valid prediction of the children's degree of success at camp. The eight characteristics are: (1) the amount of neighborhood street play the child participates in; (2) his awareness of the needs of others; (3) his ability to delay appropriate gratification; (4) his ability to follow directions; (5) the extent of his skill in playing highly organized games and also (6) his skill in playing unorganized games; (7) his gross motor coordination; and (8) his overall personal appearance.

That each of these characteristics should be related to how well a child gets along in a camp group is not surprising. What is interesting is that some of the information that can be acquired about a mentally

retarded child through the intake procedure does help to predict whether the child may become a comfortably participating member of a camp group. The extent to which an educable mentally retarded child plays with normal children in his neighborhood is probably the best single indicator of whether or not he is likely to adapt socially to a camp group. In other words, if he can "make it" in his neighborhood, he can probably "make it" at camp.

The other characteristics that are predictive of successful adaptation to camp probably also influence the mentally retarded child's ability to integrate into neighborhood play groups. Mentally retarded children who can participate in camp activities, because they are relatively skilled at playing games, have relatively good coordination, and can follow directions, will probably get along better socially than mentally retarded children who do not have the ability to participate in such activities. Also, those mentally retarded children who are sufficiently stable emotionally to be aware of the needs of others and to be able to delay gratification appropriately will probably get along with normal campers better than children who do not possess these qualities.

Other measurements

Nonparticipant observers provided another measure of how well the mentally retarded children did in camp. In the summers of 1968 and 1969, the staff of the project took part in nonparticipant observations at camp. Each mentally retarded child and the normal child selected as his control were observed

Two campers, one with normal intelligence, one mentally retarded, work together cleaning up after a camp cook-out.



twice during camp activities, including archery, soccer, swimming instruction, gathering wood for campfires, bicycle rides, folk dancing, free time, storytelling, making ice cream, and eating lunch. The staff rated each child's degree of (1) involvement in activity, (2) apparent pleasure in the activity, and (3) understanding of the activity. The analysis of these observations showed that retarded children were just as involved in activities as normal children and exhibited more apparent pleasure during activities than the normal children. The normal children, however, were rated as apparently understanding activities better than the mentally retarded children.

The counselors' observations of the children's social adjustment were also considered important. For four summers—1966 through 1969—on the last day of each session a form called the Social Adjustment Form was given each counselor, with these instructions: "It is assumed that some children seem to adjust, generally speaking, better than others. We would like to get your impression about the relative social adjustment of the children in your group. Please rank members in order of their adjustment."

A total of 93 Social Adjustment Forms were collected from camp groups that included mentally retarded children. There was some overlapping since some of the children attended more than one camp session or went to camp more than one season. On these forms, mentally retarded children were ranked above their normal controls 25 times and below 68 times. Only on 32 of the 93 forms were mentally retarded children ranked the lowest in their camp groups.

There was a notable relationship between the children's social adjustment ranking and their ratings on the Belongingness and Comfort Scale in the Group Participation Form. The higher the child was ranked on the Social Adjustment Form, the higher was his belongingness and comfort score.

Staff reactions

How do the camp director, the camp supervisors, and the counselors feel about including retarded children in camp?

In the fall of 1968, the project sent a questionnaire to 95 staff members of resident and day camps, including counselors, camp directors, and supervisors, to ascertain their reactions to the research demands, their attitudes about including mentally retarded children in the camp, and their assessment of the interaction between the mentally retarded children and

the other children. Sixty-four questionnaires were returned.

Seventy percent of the responding staff members complained that the research demands were time-consuming. Nevertheless, 21 of the 24 camp administrators and 23 of the 35 counselors responding to this question said they would like to have a retarded child in their group or lodge if they were to return to camp. Of 24 supervisors, 16 reported that they felt that the research component at camp enhanced their jobs professionally.

Thirty-one of the 39 counselors reported that having mentally retarded children in their groups made them more sensitive to the problems of other campers. Half the counselors reported that the retarded children had been no more difficult than the other children, but did require more of the leader's time.

The great majority of the responding camp staff members reported feeling that the camping experience was beneficial to the mentally retarded child. Of the 64 respondents, 44 reported that the other children did not pick on the mentally retarded children, or only did so to a minor degree; and 54 reported that the mentally retarded children did not pick on the other children, or only to a minor degree. To the question, "What do you consider the major behavior problem at camp?" 60 of the 64 replied "emotional disturbance." Only three replied "mental retardation." Eighteen of the 39 counselors responding to this question suggested that there were educable mentally retarded children at camp who should not have been accepted.

More than half the counselors reported feeling that the other children had a better camp experience because the educable mentally retarded children were included. None of the counselors said they would refuse to return to camp because of its participation in the project. Most of the camp staff members said they felt that additional precamp training would have been of value in helping counselors meet some of the special needs of the mentally retarded children.

One supervisor's statement conveys the attitude that seems to have been prevalent throughout the program:

In most cases the retarded children were indistinguishable from the other children, that is, the other children in the group usually did not recognize that their group included a mentally retarded member. I wholeheartedly approve of their attending camp with normal children.

Another supervisor wrote:

Having educable mentally retarded children at camp was a most beneficial experience for all counselors and campers.

A counselor reported:

This is not a very comprehensive survey because I had two completely different mentally retarded children. They behaved differently and affected the group differently.

Another counselor said:

The inclusion of mentally retarded children gave the normal kids an opportunity to learn about some of the troubles mentally retarded children have and to be understanding and patient.

And still another counselor wrote:

More people should be made aware of the capabilities of the educable mentally retarded child. I for one realize that they can and should be treated as any other member of the group.

But there were also negative responses. One camp staff member reported:

My personal experience with a mentally retarded child was a very trying one, for which I was drastically unprepared. In most of the problems that arose, I found that my only solution was to hand the mentally retarded child over to my supervisor.

Another respondent was doubtful:

In most cases, I don't think the counselors or junior counselors are able to understand a mentally retarded child because they have not been educated in this area. Did we really help the retarded child?

And one counselor reported:

If the groups were smaller, then more attention could be given to the mentally retarded child.

Other children and parents

What about the reactions to the mentally retarded children of the other children in the camp and their parents? Staff members of the project interviewed a normal child and one of his parents from 44 camp groups that had included a mentally retarded child. Of the 44 children interviewed, 75 percent (33) had positive reactions to the camp experience. In fact, 38 out of 44 returned to the agency's program the following winter or re-enrolled for camp the next summer. Of the 44 parents interviewed, 85 percent (37) gave no indication of having objections to the Center's continuing the policy of integration. The parents' reactions generally concurred with their children's. In 25 instances both parent and child reacted positively to the inclusion of the mentally retarded child. In eight instances the child reacted negatively to the mentally retarded child but the parent reacted positively. In three instances the

parent had negative reactions, but the child either definitely liked the mentally retarded child or did not regard him as different from the other children in his group. In only five instances did both parent and child react negatively to the mentally retarded child.

In conclusion

The EMR Project has demonstrated that many educable retarded children, when given the opportunity, can participate successfully in camp activities with normal children. The statistical findings suggest the characteristics a mentally retarded child might need in order to become a part of a group. In reality, however, retarded children showing a wide range of different characteristics have integrated adequately into the camp groups. Of the 60 retarded children enrolled in camp groups in 1969, only five children were unable to complete a session started. As one counselor reported:

The mentally retarded children had many of the same behavior problems as the so-called regular campers. Some were cooperative, some were not; so generalizations are almost impossible.

For evaluative reasons, this project included only those retarded children who were "educable." This does not mean to imply, however, that some "trainable" retarded children (IQ's 25 to 48) might not under favorable circumstances get along with normal children in a camp group. Occasionally a child from a class for "trainable" children has participated in other activities sponsored by our agency.

Often one experience is not sufficient to judge a child's eventual success; he needs to be evaluated over time. It behooves recreational agencies, therefore, to open their facilities to retarded children—some of the loneliest members of our society—to give them insofar as possible the same opportunities that are afforded other children in the community.

¹ Rosen, Alex: Theoretical concepts in the behavioral sciences regarding integration. In *Proceedings of a 1-day institute on integration of the mentally retarded in a community group service agency—a look at knowledge, methods, and gaps.* (Meyer Schreiber, ed.) Association for the Help of Retarded Children, New York, N.Y. 1963.

² National Institute of Mental Health Project, "Integration of Educable Retardates in Normal Groups," Grant No. MH-14424. Co-sponsored by the Jewish Community Centers Association of St. Louis, Mo., and the Social Science Institute of Washington University, St. Louis, Mo. (NSF grant No. G-22296.)

PSYCHOSOCIAL DEPRIVATION

WHAT WE DO, DON'T, and SHOULD KNOW ABOUT IT

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The decade of the 1960's is not the first in which we in this country have been jolted into awareness of grievous gaps between our fondly avowed principles and the realities within our borders. It is hard to believe, however, that in any earlier decade there has been more serious questing for ways to close the gaps or more acceptance—at least by a large minority of our citizens and at least on a verbal level—of the proposition that substantial and deliberate changes are necessary if we are to bring our actions in line with our words and to escape more destructive changes.

One relevant manifestation of our recognition of the need for change is the declaration of war on poverty. Another is the official acceptance of an obligation to put a floor under the economic stability and security of every family. And another is the effort to learn more about the various kinds of deprivation suffered by too many individuals and to devise ways of diminishing deprivation of every kind.

Tremendous amounts of time and effort have been devoted to learning about the causes and cures of psychosocial deprivation, and no one—least of all the persons and organizations making the efforts—has been satisfied with the results. There have been some gains and some setbacks, as well as gains that have been called setbacks and setbacks that have been called gains. So many fields, organizations, disciplines, and people have participated in these efforts that it is almost impossible for a single administrator, program planner, or investigator to know what has been learned and what has been done, or even what they need to know to understand either what has been learned or the results of what has been done.

Therefore the National Institute of Child Health and Human Development (NICHD) addressed itself to a much needed function when it “undertook a broad-based assessment of psychosocial deprivation, in order to ascertain the state-of-the-art, to identify gaps in knowledge and understandings, and to determine the implications of the findings for research policy and for social action programs.” The results have recently been made available in the publication, “Perspectives on Human Deprivation: Biological, Psychological, and Sociological.”*

The volume represents the work of four interdisciplinary task forces, established in March 1968 to produce documented reviews of research findings to be integrated into four main chap-

ters: “Psychosocial Deprivation and Personality Development,” “Influences of Biological, Psychological, and Social Deprivation Upon Learning and Performance,” “Socialization and Social Structure,” and “Biological Substrates of Development and Behavior.” The resulting chapters are based on papers contributed by 50 scientists, which were written within 5 weeks and integrated within 3 to 4 weeks. A fifth chapter summarizes the deliberations of a 2-day conference called to determine the implications of these four chapters for research policy and for social action.

The marks of haste are evident in a number of ways and places. Nevertheless, despite occasional lapses in spelling, in syntax, and in jargon, the quality of the whole is impressive. If the volume is read as widely and as carefully as it deserves, its impact could be substantial and tonic.

State-of-the-art compendiums, like dictionaries and telephone books, are written by individual people, but individual bias is likely to affect reports of research findings more than lists of telephone numbers or even definitions of words. This problem was clearly recognized by the persons responsible for synthesizing and commenting on the individual contributions: “Our aim was to give a picture of the general state of knowledge about a variable, relying largely on the conviction of a contributing author about his conclusions to judge their merit. For this reason, it is clear that specific empirical generalizations may be open to challenge; on

*PERSPECTIVES ON HUMAN DEPRIVATION: biological, psychological, and sociological. U.S. Department of Health, Education, and Welfare, Public Health Service, National Institutes of Health, National Institute of Child Health and Human Development. U.S. Government Printing Office, Washington, D.C. 20402. 1968. 346 pp. \$2.75. (Single copies free on request from Information Office, NICHD, NIH, Bethesda, Md. 20014.)

the other hand, we feel some degree of confidence in the overall reviews as representing the 'state of the art' in their respective areas." (P. 65.)

Welcome realism

Both the reservations and confidence expressed are well justified. The volume is notable for the vast amount of useful information it brings together. Even though at some points the "specific empirical generalizations" are indeed open to challenge, a number of the individual contributions show evidence of scrupulous care and offer analysis that is both illumined and illuminating. The volume is even more notable for the judiciousness of the overall commentaries and for their realism in assessing gaps in information and shortcomings in current research methods and approaches.

Perhaps this realism will prove to be the primary contribution of the publication. One might hesitate to expose the uninitiated student to some of the "specific empirical generalizations" it contains. Nevertheless, this same student could profit greatly by the summarized discussions that point out not only substantive findings, but also (where appropriate) moot points, contradictory conclusions, the dangers of focusing on single variables in a complex field of interacting forces, and the inadequacy of popular research models to cope with such complexity.

Some of the points made in the synthesizing commentaries merely give weight, substance, and the sanction of respected authorities to familiar principles so far more honored in the breach than in the observance. Among these are discussions of defects in controls for socioeconomic status, known among researchers as SES controls, and the consequences of those defects. It is noted, for example, that among some 240 studies reported in Shuey's review of the literature on comparative intelligence testing, "in only 17 . . . is social class position of the subjects taken into consideration in some way"—and that most of the studies "have serious methodological flaws." (P. 121.)

Other points constitute recognition of new variables or dimensions to be taken into account in studying the effects of deprivation or contribute clues to new ways of perceiving familiar elements. Among these is recognition of Bronfenbrenner's "valuable distinction between

consequences stemming from early stimulus deprivation and consequences stemming from the frustration of an established dependency drive between an infant and a person who satisfies his oral and dependency drive" (p. 57).

Another is found in the synthesizer's comment that "the deprivation metaphor is, to some extent, logically misleading in that it suggests that the explanation of the phenomena of disadvantage lies in what is absent rather than in what is present . . . the important point is that development is likely to be invariant with or related to the conditions which are present, not with those which are absent. . . . Those target populations commonly characterized as deprived are better described as disadvantaged, a term which makes no commitment to an insufficiency model. What is then needed to replace the explanatory contribution of the deprivation term is the refined and careful study of variation. . . ." (P. 3.) The distinction is aptly illustrated in relation to the effects on children of their father's absence.

New vistas

Because of the authority inherent in its authorship and auspices, this volume could represent a point of departure from the acceptance of research patterns and methods long in need of challenge to the evolution of patterns and methods of research more suited to present needs and more conducive to the development of effective methods of intervention. Conceivably, the vistas it opens could become visible not only to those humbled and seasoned by years on the firing line, but even to those who, in university courses and seminars, teach and learn much that must later be painfully expanded, modified, or shoved aside.

Such vistas include the recognition of what we do not yet know. We are not always sure what variables are relevant and what their respective roles are in the processes, situations, and conditions to be studied. We need much more descriptive research, much more true collaboration between the different disciplines. We also need more testing with carefully evaluated and replicated clinical trials and pilot projects before large-scale programs of intervention are launched. If such requirements are recognized, scrutinized, and explored, they

should lead to the fostering of new approaches to research and new definitions—including a rethinking and redefining of that weapon word "rigorous." If this means discarding a few academic shackles and blinkers, so much the better.

Some of the most arresting and thought-provoking passages in the summaries of this volume are the discussions of what still needs to be learned and the linkages required for adequate investigation. It is pointed out, for example, that social scientists involved in developing programs for cognitive enrichment have rarely benefited from what the field of linguistics could contribute.

With regard to research policy, "Perhaps the overriding need is for greater flexibility in funding . . . research that may have great relevance for understanding the deprivation phenomenon but which does not meet the ordinary requirements of classical study design" (p. 341)—an indication of where money stands in the hierarchy of values and of how closely it is linked with professional orthodoxy. One might add that if orthodoxy prevails in approving only a limited array of classic models for research and demonstration grants, and if projects are designed chiefly with a view to producing an attractive package that will please the keepers of the purse, productive groping and daring departures from the sanctioned models of the moment are bound to be inhibited.

The recommended flexibility should apply especially to methods of evaluation, if we are to escape the frequent tail-wags-dog situation in which the evaluation imperative wags the program. It is time for a bold new look at methods of evaluating programs of intervention and at some assumptions underlying these methods, including assumptions about the kind of accounting that must be offered to pursekeepers if funds are to be forthcoming. The new look should encompass the opportunity for a program to grope, to change, to grow, before it is frozen into an evaluation scheme on which renewed funding depends.

Who should be studied?

The NICHD publication omits detailed discussion of appropriate target groups for research in behalf of social action, for that was not its mandate.

Nevertheless, any consideration of psychosocial deprivation underscores the importance of questions that have been raised from time to time but have not received nearly enough attention and that threaten to demand some agonizing reappraisal if they are neglected much longer. Foremost among such questions is "Who should be studied?"

We have spent much time and many dollars investigating "the deprived," whether their deprivations are physical, social, psychological, legal, or a combination of these and other disadvantages. We will need to continue such efforts. But there is also a need to study those segments of society that must change if any real inroads are to be made on many aspects of psychosocial deprivation and on the closely intertwined economic deprivations.

This was a major message of the Kerner report,¹ which brought home the need to study the white population and effect changes in its attitudes and practices if belated justice is to come to those we are learning to call "black." A parallel message concerns the need to study the nonpoor if we are really to win the war on poverty. How does a nation learn to change its values? How can the "haves" be persuaded to make room in their ranks for those who now are the "have-nots"? What structural changes are necessary to make our avowed goals a reality?

Earlier research on intergroup relations has attempted to discover the roots of prejudice and clues to ways of replacing them by more healthy growths. Such names as Allport, Jahoda, and Stuart Cook come to mind, among others. We need to build on such research, to profit by all it offers, but to go much further in exploring the various kinds of gain (real and illusory) reaped by the advantaged from the very existence of the disadvantaged. We need to discover what actually exists and what would be necessary to make real change acceptable.

There are those who maintain that change can be accomplished only through fear and so see a positive value in urban violence and destruction. If this be so, we still need to learn more about those who feel threatened, the kinds of changes that could turn their fear into constructive channels, and the

steps through which these changes could be brought about most effectively and with least penalty to society.

There are those, however, who believe that a prosperous nation, if it has the will, can voluntarily conquer human misery within its own boundaries as surely as it can conquer the less difficult problems of space travel. But a determination to end human misery cannot succeed if our efforts are focused only on one-half of the socioeconomic equation.

The current mood among "the poor" and "the black," who are beginning to resist the avalanche of investigation, is likely to promote recognition of the need to study the other half of the equation—the nonpoor and nonblack and nondeprived.

"We're under that microscope 24 hours a day," declares the president of a Negro college student council.

"I'm just like a walking test at school," says an innercity Negro girl who is one of a selected few being bussed to a white suburban high school. "Now the Negro is on stage, performing before an all-white audience, trying to sway and correct their opinion of blacks."

Recipients in the program of aid to families with dependent children are evincing resentment at the questioning and instruments of researchers. Other inhabitants of our urban slums are beginning to view high-minded and conscientiously probing research interviewers with the same annoyance as members of the middle class tend to regard the door-to-door salesman.

One answer to the problem posed by such aversion may be that the new approaches advocated in the state-of-the-art assessment of research in psychosocial deprivation must include ways of learning what needs to be known that do not depend on direct interviewing and testing—methods that in any case involve a number of other drawbacks, including some documented delusions about the significance of their results. Another answer, however, may be to shift, or at least broaden, the focus of attention to include the groups whose change is indispensable to relieving various kinds of deprivation.

It is often said that learning to ask the right questions is the essence of

good research. Asking the right questions will inevitably lead to a shift in definitions of appropriate target groups in various areas of research. Protesting students, for example, are now mounting protests against being made the focus of so many studies. They maintain that studies of dissident students are used to screen activists from college campuses and may be used in other ways to the disadvantage of those identified as dissidents. And they insist that the proper subjects for studies of campus unrest are the college administrators, the trustees, and the faculty. At least it can be argued that these groups should not be omitted from serious study of our colleges and universities.

Know thyself

Nominations for more appropriate groups to be the targets of research could be multiplied, but one final entry will suffice. The research of social scientists influences intervention programs a great deal more today than in the past. Social scientists exercise more influence and earn more money today than at any other time in the history of the relatively young field of social research. This development has had dramatic effects on the field, on the crops it yields, and on the people who will till it. Perhaps it is time to include among our study targets the social scientist himself—his career history, his attitudes, his goals, his rewards, his interrelations with members of his own and other disciplines, his value, his *modus operandi*, his affiliations, and above all his self-image, and how all these affect his product, his recommendations, and the evolution of social research.

Since support for research is typically granted or withheld on the advice of social scientists, and since many intervention programs are designed, modified, and evaluated by social scientists, such study would be highly relevant to present social needs and programs. This seems a wholesome moment, therefore, to paraphrase an old injunction: Student, study thyself.

¹ U.S. National Advisory Commission on Civil Disorders: Report. U.S. Government Printing Office, Washington, D.C. 1968.

BOOK NOTES

STILL HUNGRY IN AMERICA. Robert Coles. Photographs by Al Clayton. Introduction by Edward M. Kennedy. New American Library, Inc., in association with The World Publishing Co., Cleveland, Ohio. 1969. 115 pp. \$6.95.

By quoting mothers, fathers, children, and grandparents whom he interviewed in rural areas of the South, the author of this book builds up evidence to document the statement used as a title. He first reported some of the conditions of poverty presented in this book to a committee of the U.S. Senate in 1967 after a visit he made to Mississippi with five other physicians. In a narrative that is closely tied to 110 black-and-white photographs taken by Al Clayton, the author describes "a terribly shameful, unsettling, and edifying view of the extreme distress and redemptive possibilities that continue to exist, side by side, in the very same people."

DELINQUENCY IN GIRLS. John Cowie, Valerie Cowie, and Eliot Slater. Humanities Press, New York, No. 4. 1968. 220 pp. \$6.

Unsatisfactory home life emerged as a main cause of juvenile delinquency in a study of 318 adolescent girls committed by juvenile courts to an "approved" residential school in London, England, according to the three psychiatrists reporting their findings in this book. The authors rated less than 20 percent of the homes of the delinquent girls as "normal," although 44 percent of the girls lived with both parents at the time of commitment in 1958. They report that half the girls were deprived of normal maternal love and care at the time they were adjudged delinquent.

Three-fourths of the girls were adjudged delinquent because of sexual misconduct and the rest because of shoplifting, other forms of larceny, breach of probation, vagrancy, or similar offenses.

In their conclusion, the authors discuss their clinical judgments on the girls studied, the differences between boy and girl delinquents, and factors predisposing to delinquency, including chromosome irregularities and environmental influences such as overburdened mothers, lack of discipline, and homes inimical to healthy development. They strongly urge removal of neurotic or delinquent children from hostile homes.

FORGOTTEN CHILDREN: a program for the multihandicapped. Merle E. Frampton, Ellen Kerney, and Regina Schattner. Porter Sargent Publisher, Boston, Mass. 1969. 287 pp. \$6.95.

A continuing demonstration project in the education of severely handicapped, blind, cerebral-palsied children at the New York Institute for the Education of the Blind is described in this book. The authors, all of whom were associated with the project, point out that the institute has used findings from the first 6 years to set up a diagnostic clinic for the educational placement of multihandicapped children.

From 1956 to 1962, a total of 30 blind, cerebral-palsied children—many of whom had additional handicaps—were accepted into the project. Enrollment varied from 12 to 17 children, ranging in age from 7 to 17; all but three of the children remained at least 2 years.

The project was designed to identify and serve the needs of such children, to develop various levels of curricula adaptable to them, to do research in teaching techniques, and to formulate principles for training teachers and other personnel. The 11- to 14-member staff included a director-teacher, one or two other teachers, a pediatrician, a physical therapist, a speech therapist, a housemother, and attendants.

The authors report that 24 children showed progress while they were in the project. Of these, eight were found educable and placed in academic classes

at the institute; eight were found "trainable"—able to make their needs known or to take care of their own needs—and partly educable; eight were found trainable. Six were found not amenable to training because of extreme behavior patterns or inability to communicate.

According to the authors, the staff members' first task was to determine the extent of each child's handicaps. They then helped each child increase the use of the senses that he did possess. Within the therapeutic setting, the staff provided a carefully structured day with some group experiences. Children were placed in a kindergarten group, a trainable group, a group that offered individual help with special learning problems, and academic classes in the institute. Parents were drawn into the project through conferences with the staff and an annual parents' day.

The authors emphasize the need for a total rehabilitation program for multihandicapped children that begins before they reach school age; a multifocal school in which children are assigned to classes according to their own development, not their handicaps; and teachers with special qualifications and training.

DIALOGUE WITH SAMMY: a psychoanalytical contribution to the understanding of child psychosis. Joyce McDougall and Serge Lebovici. International Universities Press, New York, N.Y. 1969. 273 pp. \$7.50.

Analysis of psychotic children is "possible and valuable," say the two child psychiatrists who wrote this book about 8 months of psychoanalytic treatment of a 9-year-old schizophrenic American boy in Paris. Analyst Joyce McDougall uses a diary form to record Sammy's conversations with her during which he revealed the fantasy world in which he lived, his anxieties, his inability to cope with reality, and his progress under treatment. She presents notes and comments on her own efforts to understand Sammy and to help him understand himself.

This first edition in English is a revised translation by Dr. McDougall of *Un Cas de Psychose infantile*, first published in French in 1960. It contains verbatim extracts from many of the 166 treatment sessions with Sammy, including stories that Sammy dictated to "Dougic," and some of his drawings.

HERE and THERE



Reorganization in HEW

On September 17, Secretary Robert H. Finch announced a reorganization of the children's services within the Department of Health, Education, and Welfare. The reorganization gives the Office of Child Development, established in the Office of the Secretary under the supervision of the Assistant Secretary for Administration last July, three bureaus:

- The Children's Bureau, transferred from the Social and Rehabilitation Service, to perform the functions assigned to it by Congress when the Bureau was created in 1912—"to investigate and report on all matters pertaining to the welfare of children and child life among all classes of our people"—to carry out research, demonstration, and training functions, to coordinate the programs for children and parents throughout the Department, to promote programs for youth, to identify areas requiring the development of new programs, and to serve as an advocate for children.

- The Bureau of Head Start and Early Childhood, to administer the Head Start and Parent and Child Center programs, which were transferred last July from the Office of Economic Opportunity, and to develop policies and standards for day-care programs and provide technical assistance to State agencies administering day-care programs.

- The Bureau of Program Development and Resources, to develop standards, guidelines, and technical assistance materials regarding services to children and youth with the exception of preschool and day-care programs, to work with State and local agencies and private organizations to stimulate increases in the availability and quality

of children's services, and to publish materials for the general public and for persons engaged in services or training programs for service personnel, including the interdisciplinary journal *CHILDREN*.

The director of the Office of Child Development will also serve as Chief of the Children's Bureau, a Presidential appointment. The director will report to the Secretary through the Assistant Secretary for Administration, James Farmer.

The reorganization established a new unit within the Health Services and Mental Health Administration of the Public Health Service, to be responsible for the health programs that were formerly administered by the Children's Bureau—maternal and child health services, crippled children's services, the special projects for maternity and infant care and comprehensive care for preschool and school-age children, and health research.

A new unit has been established within the Social and Rehabilitation Service, the Community Services Administration, to administer the programs under title IV of the Social Security Act formerly administered by the Children's Bureau—child welfare services, services to families in the program of aid to families with dependent children (AFDC), and the Department's responsibilities for the work incentive program (WIN), including child care for AFDC families—and also to administer services for aged and handicapped persons who are recipients of public assistance.

The Assistant Secretary for Administration has been appointed chairman of a newly established Board of Advisors on Child Development, which also includes the Assistant Secretaries for Education, for Health and Scientific

Affairs, and for Planning and Evaluation, the Administrator of the Social and Rehabilitation Service, and the Director of the Office of Child Development. The Board will advise the Secretary on policy, organization, and coordination of programs, strategies for research, training, and demonstrations, and priorities for funding in the field of child development. The Secretary will also establish a National Advisory Committee on Child Development to include professional persons, parents, and program officials to be concerned with the early childhood programs throughout the Department.

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In late July, the Secretary transferred the staff of the 1970 White House Conference on Children and Youth from the Children's Bureau to a new unit in his own office called the Secretary's Office for the White House Conference.

School desegregation

Students, teachers, and parents in school districts that have voluntarily desegregated since 1964 generally have positive attitudes toward the experience, according to the findings of a survey conducted in the spring of 1969 by the Southeastern Regional Office for Civil Rights of the Department of Health, Education, and Welfare. The survey involved interviews with 1,230 students, teachers, administrators, and parents in 13 school districts in the South that had voluntarily desegregated under the Civil Rights Act of 1964 and had experienced some desegregation for 2 years. The districts are located in Florida (with the only urban district, Dade County, included in the survey), Georgia, Mississippi, South Carolina, and Tennessee.

As many black interviewers as white interviewers were used. Interviews, arranged so that white interviewers interviewed both white and black persons, and vice versa, were held with 115 white and 13 black administrators, 208 white and 128 black teachers, 20 white and 150 black parents, and 22 white and 180 black students in grade eight through 12. Most of the schools involved were formerly all-white schools which were now majority white; five were previously all black or almost all black and now had either a majority or a large minority of white students.

The persons interviewed were asked how they viewed desegregation as it affected the learning process, the teaching experience, extracurricular school activities, and social activities.

The learning process: The majority of white students and white and black teachers said they felt that there was little or no difference in academic standards or in the white students' learning progress since desegregation and that black students were learning more. A majority of black students and their parents said they felt that the black students were receiving better schooling in the desegregated schools. White parents tended to be more critical, but generally agreed that the school standards had not changed.

The teaching experience: A majority of students of both races said they felt that the race of the teacher did not affect the quality of teaching and that the teachers were teaching without racial favor or prejudice. Most parents of both races expressed satisfaction with the teachers assigned to the schools; some white parents said they had been worried at the start, but had been reassured by their children. Most teachers of both races noted an academic gap between white and black students, but said that both racial groups were within the same range of abilities. Most teachers reported being concerned about disciplinary problems. White teachers reported good relations between black and white teachers, but black teachers reported varying opinions—from being accepted to being ignored or merely tolerated. Most of the administrators said they felt that teachers of both races who had been successful in teaching in segregated schools were experiencing no real difficulty in the desegregated schools.

Extracurricular activities: Most of the persons interviewed generally agreed that extracurricular activities were open to all students but that no efforts were being made to recruit or encourage participation by black students. White students saw no difference in participation in activities, while black students saw themselves as under-represented. Black teachers and students gave as reasons for the black students' nonparticipation: lack of interest, a feeling of not being welcome, strangeness of new students facing established groups, and discouragement by parents.

Social activities: In most of the school districts, both white students and black students were taking part in official social activities without incident, but problems existed in regard to informal relationships. Students, parents, and teachers of both races reported relations between black and white high school students as varying from uneventful toleration to tension and hostility. Racial tension was reported to be more prevalent in high schools than in elementary schools and more prevalent among girls than boys.

Foster care

More than 5,000 children in Los Angeles County, Calif., have been placed on an emergency basis in temporary foster homes in the past 3 years by the Los Angeles County Department of Public Social Services in an around-the-clock emergency service called the Good Neighbor Program. The program operates 24 hours a day, 7 days a week, to serve nondelinquent children who need temporary shelter.

The Department now has available 199 families licensed to provide foster care by the State of California who are ready to care for children in emergencies. Many of the couples recruited for this purpose were already serving as foster parents. Good Neighbors receive \$3 a day, or \$91 a month, for the maintenance of each temporary foster child in their homes.

The Good Neighbor Program was developed by Mary M. O'Neill, chief of Family and Children's Services, so that nondelinquent children would not have to be placed in a juvenile detention facility when they needed emergency shelter. Children have been referred to Good Neighbor homes when they were abandoned, severely neglected, abused, or inadequately supervised, and during a crisis in the family, such as murder, attempted suicide, arrest, or emergency hospitalization of a parent. Thus far, about half the children who have been served by Good Neighbors have been returned to their own homes.

When a law enforcement officer learns of a child who needs immediate temporary shelter, he contacts the County Department of Public Social Services. During the day, referrals are made to the appropriate district office; from 5 p.m. to 8 a.m. and on weekends, they are routed through a 24-hour telephone

answering service to the child welfare worker assigned to be on call in her own home to handle emergency placements. Four child welfare workers serve alternately on all-night duty and weekend duty to provide referral service at all times. The child welfare workers are paid for 3 hours of overtime when they take all-night duty and for 8 hours of overtime for 24 hours of duty on Saturday and Sunday.

When the child welfare worker on 24-hour duty receives information about the needs of a stranded child (or children), she gets in touch with a Good Neighbor who lives close to the child's home and arranges for his care. Then she notifies the officers where to take the child.

During the next regular working day, a child welfare worker brings a clothing allowance to the Good Neighbor's home and provides necessary casework service for the child. If there is an acute medical problem, the Good Neighbor may take the child to her own doctor at the Department's expense. The Good Neighbor may also use the 24-hour answering service to contact the on-duty child welfare worker when a problem arises.

A child may remain with a Good Neighbor family for a month; if he continues to need foster care for a longer period, he is moved to a more permanent foster home. On the average, children stay in Good Neighbors' homes for 16 days.

Education

Enrollment in public elementary and secondary schools in the United States reached 45.6 million pupils this fall, according to estimates by the U.S. Office of Education. The estimates for 1969 project an increase of about 600,000 students over the record enrollment of 44,962,000 for the fall of 1968.

The 1968-69 school year also brought new peaks in teacher employment (1,943,000), financial expenditures for public elementary and secondary education (\$35.5 billion), average teacher salaries (\$7,900), and outlay per pupil in attendance for full-time public schools (\$696). Public high school enrollment in 1968 gained 3.9 percent from 1967. The 2.4 million public high school graduates in 1968 represented 77.6 percent of the class that entered the ninth grade in 1961, compared with 70.9 per-

cent of the ninth grade students in 1959 who remained in school until graduation in 1963.

In 1968, preschool enrollment of children under 6 years of age went up about 94,000 from the previous year, with most of the increase occurring in kindergartens. The 3.92 million children in the first grade in 1968 represented a small decrease from the 3.97 million children in the first grade in 1967.

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Discovering how children in primary grades learn to read and then describing the process is the goal of a new project supported by the Office of Education, one of 28 that are extending basic research in education into such fields as psychology, philosophy, sociology, anthropology, and mathematics.

The projects, which are being conducted at universities and in research centers, are all aimed at advancing knowledge about basic learning problems. A Committee on Basic Research in Education, jointly sponsored by the National Academy of Sciences and the National Academy of Education, selected the research projects.

One of the other projects involves studying the link between motivation to achieve and uric acid, a stimulant similar to caffeine; and another one is attempting to discover the various ways in which children classify words, as an aid to learning and remembering.

Family planning

Research in the development of new methods of contraception is underway in universities, nonprofit organizations, and pharmaceutical companies in 24 States and Canada under 72 contracts made with the Center for Population Research of the National Institute of Child Health and Human Development (NICHD) in the year since the Center's establishment in August 1968. The contracts involve a total of \$2,881,000, of which \$1.5 million was transferred to NICHD from the Agency for International Development.

The goal of the research, according to Gerald D. LaVeck, M.D., NICHD's director, is to develop "an array of contraceptive methods that are effective, safe, reversible, inexpensive, and suited to the diverse requirements of the world's varied population groups."

The Center has also awarded eight

contracts, involving a total of \$1.2 million, for studies on the medical effects of contraceptives, including investigation of oral contraceptives and stroke.

In addition, the Center has made 12 contracts, totaling \$668,751, for studies in the behavioral sciences to determine effective methods of providing family planning programs, to assess future population trends, and to investigate factors influencing the use of contraceptives.

For the deaf-blind

A new National Center for Deaf-Blind Youth and Adults, designed to provide rehabilitation services for deaf-blind persons, is being established at the Industrial Home for the Blind in Brooklyn, N.Y., under a \$600,000 grant awarded in June by the Social and Rehabilitation Service.

The Industrial Home, in an 8-year demonstration project supported by SRS, has extended its services to deaf-blind clients in 15 States in the northeast and mid-Atlantic regions. It is currently serving 230 deaf-blind persons, of whom 59 are children.

The center will offer such rehabilitation services as medical, psychological, social, and vocational evaluation; speech therapy and language development; training for independent travel; vocational training for employment in sheltered workshops; and resettlement for those able to enter the regular work force. Regional offices in the Midwest and Far West are planned.

The establishment of a National Center for Deaf-Blind Youth and Adults coincides with the establishment of eight regional centers that focus on education of deaf-blind children, set up by the Office of Education to meet the needs of children born with double handicaps as a result of the rubella epidemic of 1963-65.

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Five regional centers to serve deaf-blind children in 26 States began operation on June 1. Coordinating agencies for these centers are the Alabama Institute for the Deaf and Blind, Talladega; California State Department of Education, Sacramento; Perkins School for the Blind, Watertown, Mass.; New York Institute for the Education of the Blind, New York City; Washington State School for the Blind, Vancouver.

Three other regional centers are planning and developing programs. Coordinating agencies for these centers are the Michigan State School for the Blind, Lansing; Callier Hearing and Speech Center, Dallas, Tex.; and Colorado State Department of Education, Denver.

Miscellaneous

A new organization, the Race Relations Information Center, is beginning operations in September in Nashville, Tenn., as the successor to the Southern Education Reporting Service (SERS). The center will gather information on major aspects of race relations in the United States, carry out journalistic inquiries in the field of race relations, provide reports through news media, and issue occasional papers for general distribution. Its predecessor, the SERS, was an organization founded by a group of Southern journalists and educators in 1954 to report regularly on the results in the South of the decision of the Supreme Court of the United States on school desegregation in May of that year.

The final issue of its periodical, *Southern Education Report*, appeared in June 1969. In it Harry Ashmore, former newspaper editor in Little Rock, Ark., points out that the prospect of a racially divided nation can no longer be charged to the South alone, but is "American now, in every sense."

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A collection of teaching materials related to children and their welfare is now available from the Council on Social Work Education. Prepared under a grant from the Field Foundation, the materials include visual aids, audio tapes, teaching records, a source book, an annotated bibliography, and a casebook. These materials are designed for the use of students and faculty members in schools of social work, staff development officers in health and welfare agencies, and teachers in fields related to work with children and their families.

Subject-matter includes concepts of growth and development, methods of working with children and youth, problems and needs of children and families, interaction between individuals and groups, and attitudes. Information about specific materials, which may be ordered individually or as a package,

may be obtained from the Council on Social Work Education, 345 East 46th Street, New York, N.Y. 10017.

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Four leaflets containing information on poison prevention, medical care, education, and social security designed specifically for persons living in inner-city neighborhoods have been developed by the Watts Writers Workshop of Los Angeles for the Department of Health, Education, and Welfare. "Poison: Child

Playing" provides steps for preventing accidental poisoning in children. "When You Go To The Doctor" tells what to expect in a medical examination. "Do Your Own Thing" stresses the importance of staying in school and outlines some educational opportunities. "Protect Your Future" tells why it is important to get a social security card.

The Watts Writers Workshop, whose participants wrote and illustrated the leaflets, is sponsored by the Douglas House Foundation to provide residents

in innercity neighborhoods opportunities to meet for discussions and to receive instruction in creative writing, drama, dance, journalism, consumer education, and photography. It was founded by novelist Budd Schulberg in the wake of the Watts disturbances in August 1965. The workshop participants range in age from 8 to 80 years.

Copies of the leaflets are available on request from the Department's Information Center, Room 1528, North Building, Washington, D.C. 20201.

IN THE JOURNALS

Sudden infant death

Ways of helping parents surmount the emotional trauma of having found an apparently healthy infant dead in his crib are described by Margaret R. Pomeroy in the September 1969 issue of *American Journal of Nursing*. ("Sudden Death Syndrome.") As a nurse in a 3-year research study of the sudden death syndrome (SDS), the author visited 130 families the week after the death of their infant. She reports that the experience has convinced her of the importance of the following measures: the performance of an autopsy and a telephone report to the parents by the doctor who made it; the distribution of a fact sheet on what is known and not known about this mysterious phenomenon; a followup visit to the families of SDS victims by a professional person who is "knowledgeable about the subject" and "familiar with the art of counseling"; and the offer to families of emotional support from other parents who have gone through the same experience.

Stating that more is known about what does not cause such sudden infant deaths than is known about the causes, the author cites a fact sheet distributed by the Children's Orthopedic Hospital in Seattle, Wash., that makes the following points: SDS is neither predictable nor preventable; the victims do not suffocate or suffer; SDS is not heredi-

tary nor is it infectious in the usual way; the disease is as old as Biblical times and occurs in all parts of the world. SDS, the author reports, kills one in 500 infants born in the United States. She describes the nurse's role in relation to sudden infant death as: (1) starting procedures for the identification and reporting of all SDS cases; (2) setting up a program for visiting the families of SDS victims; and (3) holding inservice education programs to prepare nurses for helping families.

Births out of wedlock

In an analysis of trends in illegitimacy since 1940, in the August 1969 issue of the *Journal of Marriage and Family*, Stephanie J. Ventura points to a slight decline between 1965 and 1966 in the rate but not in numbers. She also notes that between 1940 and 1957, the illegitimacy rate rose rapidly, but since 1957, has increased very little. ("Recent Trends and Differentials in Illegitimacy.")

Explaining that the rate of illegitimacy is based on the number of births per 1,000 unmarried women between the ages of 15 and 44, the author, a statistician at the National Center for Health Statistics, reports that the rates that declined the most were those that have been highest—for women 25 to 29 years old, and for women 30 to 34 years old. She also points out that much of the

decline in the illegitimacy rate for all women could be accounted for by a decline in the rate for nonwhite women and that in contrast, the rate for white women increased, thus continuing a reduction in the differential in the rates for the two groups that has been occurring since 1950. She reports that between 1960 and 1966 the illegitimacy rate for nonwhite women declined 6 percent, while the rate for white women increased 30 percent.

Pointing out that, nevertheless, the illegitimacy rate was higher among nonwhite than among white women—92.8 and 12.0 respectively in 1966—the author suggests that the differential between the two groups may be based at least in part on the following factors: a difference in the proportion of women who marry following the discovery of a premarital conception; a greater likelihood of underreporting among higher economic groups; the possibility that white unmarried couples make greater and more effective use of contraceptives than nonwhite unmarried couples.

Advocates for health

A neighborhood health center in the Bronx, New York City, has the distinction of being the first center with a health advocacy department, reports Penny Urvant, a staff writer for *Volunteers in Service to America (VISTA)* in the September 1969 issue of *Public Health Reports*. ("Health Advocates.") Located in the Martin Luther King, Jr., Health Center, sponsored by the Montefiore Hospital, the health advocacy department consists of five lawyers who work to help people of the neighborhood obtain their health-related rights or to

remedy grievancees. In doing so, the author reports, they represent neighborhood groups in legal actions, give lectures in the neighborhood on the law in relation to consumers, tenants, the mentally ill, and other groups; and consult with the center's staff on the legal rights of its patients.

According to the author, the health advocates work primarily with groups—gathering data for lawsuits concerning sanitation, advising tenant groups on rent strikes, handling the incorporation of a group starting a day-care center or a credit union—but they also help individuals secure their full rights under public programs.

Changing racial attitudes

A study to change preschool Caucasian children's attitudes toward the colors black and white, and hence their racial attitudes is described in the September 1969 issue of *Child Development*. ("An Exploratory Study of the Modification of Color and Racial Concept Attitudes in Preschool Children," by John E. Williams and C. Drew Edwards.)

The authors, both of the psychology department of Wake Forest University, report that laboratory reinforcement procedures employed to weaken the children's negative evaluation of the color black were followed by evidence of reduction in the children's tendency to respond negatively to pictures of black people and positively to pictures of white people.

The study involved eighty-four 5-year-old kindergarten children—46 boys and 38 girls from middle class Caucasian families. To test their concept attitudes toward the colors black and white at the beginning of the experiment, they were shown 12 cards, each with two drawings of an animal or a toy, identical except that one was black and the other white. After a brief story the children were asked to identify which of two drawings the story referred to and in doing so they had to use an evaluative adjective such as *clean, nice, good or dirty, naughty, bad*. The same cards were shown to the children four times, each time with a different story. On the whole the children tended to give positive responses for the white

pictures and negative for the black.

The laboratory procedures, as reported in the article, involved showing the children the same picture cards 2 weeks later, again four times for each card, but in this session the children were asked to guess the ending of a story. A right guess resulted in an award of candy; a wrong guess in the forfeiture of one of 30 pennies given to the child at the beginning of the session. In each case the "correct" answer placed the black animal or toy in a favorable light.

Two weeks after their second session the children were asked to "play the same game" with cards picturing people, also identical except for color, but this time they were given no rewards until the end of the game. A group of children who had not had the reinforcement sessions were also asked to "play the game."

The authors report that only 48 percent of the children who had had reinforcement procedures showed negative attitudes toward the drawings of black people as against 70 percent of the children in the control group.

guides and reports

NURSERY SCHOOL PORTFOLIO. Association for Childhood Education International, 3615 Wisconsin Avenue NW., Washington, D.C. 20016. A kit of 16 leaflets. 1969. \$1.50. (Individual leaflets, 20 cents each.)

Discusses whys and wherefores of nursery schools and various aspects of starting and operating one.

RECOMMENDED READING ABOUT CHILDREN AND FAMILY LIFE. 1969. Child Study Association of America, 9 East 89th Street, New York, N.Y. 10028. 1969. 74 pp. \$1.95.

Contains an annotated list of over 270 books, most of them published during the 1960's on subjects related to family life and child rearing, including a section on books for children confronted

with special situations, such as adoption, broken homes, physical disabilities, or racial discrimination.

MINNESOTA SYMPOSIA ON CHILD PSYCHOLOGY, Vol. 2. John P. Hill, editor. University of Minnesota Press, Minneapolis, Minn. 55414. 1969. 172 pp. \$5.

Presents five papers from a 1967 symposium on research in personality development in children sponsored by the Institute on Child Development of the University of Minnesota.

PLANNING AND IMPLEMENTING SOCIAL WORK PROGRAMS IN COMMUNITY HEALTH SERVICES FOR MOTHERS AND CHILDREN: proceedings of tri-regional workshop, Hotel Webster Hall, Pittsburgh, Pa.,

February 26–March 1, 1968. Public Health Social Work Program, Graduate School of Public Health, University of Pittsburgh, Pittsburgh, Pa. 15213. 1969. 165 pp. Free from the University's Public Health Social Work Program.

Contains a compilation of papers from a workshop cosponsored by the Children's Bureau and the University of Pittsburgh, dealing with the planning and carrying out of social work programs in maternity and infant care or children and youth comprehensive health care projects.

THE SEX EDUCATOR AND MORAL VALUES. Isadore Rubin. Sex Information and Education Council of the U.S., 1825 Willow Road, Northfield, Ill. 60093. SIECUS Study Guide No. 10. February 1969. 25 pp. 50 cents.

A guide for helping young people make their own decisions among a "conflicting array of sexual values."

READERS' EXCHANGE

BRIELAND: A reinforcement

Donald Brieland's article, "Black Identity and the Helping Person" [*CHILDREN*, September-October 1969], reinforces both the National Urban League's position and my personal conviction that the black population is more interested in the quality of service than the race of the helping person. The results of a similar study by Dr. Sumati Dubey, using a sample of 535 persons (larger than Dr. Brieland's sample), indicate an even greater "no preference" for race and a greater preference for competence. (Dubey, S. N.: "Blacks' Preference for Black Professionals, Business and Religious Leaders at a Community Level," School of Applied Social Sciences, Case Western Reserve University, Cleveland, Ohio, 1969, unpublished report). Historically, the Urban League has always and will continue to function on the principle that it is an integrated voluntary organization offering services based on competence, not race.

However, there are some other very strong implications for helping persons, particularly in the profession of social work, in both Dr. Brieland's and Dr. Dubey's studies. The focus of both studies is on the individual, specifically the black individual. The great need is for focusing on institutions serving blacks so that effective changes can be brought about in order to begin to offer relevant services to the black population. It is imperative that we look at the social service institutions that have failed to serve the black population effectively. The burden of responsibility must be placed on these institutions and not on the black families and individuals.

Dr. Brieland stated that his study "... also emphasizes for white people who work in predominately black neighborhoods the importance of being sensitive to the broad implications of the emerging emphasis on black iden-

tity." The importance of this must not be minimized. In fact it is one of the standards for measuring competence. However, the sensitivity must go beyond just sensitivity. Sensitivity to this sense of identity must be the first step in the process of involving blacks in decisionmaking roles throughout all the institutions' activities—as workers, supervisors, administrators, and members of the policymaking boards.

Dr. Brieland suggests the need for further studies in this area. I suggest the need for an all-out effort to bring about changes in institutions serving black families and individuals. My own agency is developing models for systems' change and confrontation in our efforts to help social welfare agencies retool services to become more relevant and responsive to the needs of the black community. Articles like Dr. Brieland's only continue to indicate that black people—like other Americans—desire competent workers who can offer quality service. It is now time for the institutions to respond to that need.

Whitney M. Young, Jr.
Executive Director
National Urban League, New York

LEWIS, McCOLLUM, SCHWARTZ, and GRUNT: *Informed consent*

The thoughtful article by the Yale group deals with important unresolved difficulties in insuring "informed consent" as a prerequisite for formal research involving children. ("Informed Consent in Pediatric Research," by Melvin Lewis, Audrey T. McCollum, A. Herbert Schwartz, and Jerome A. Grunt, *CHILDREN*, July-August 1969.) However, I am concerned that the difficulties may be considered so formidable that they discourage much needed systematic investigation of disease in children and force physicians to fall back on the unplanned, anecdotal method to solve their clinical problems.

I suggest that "informed consent" for research must be viewed in the perspective of the everyday relationship between the physician and his child patient. Much of daily pediatric practice is, in reality, informal experiment which requires at least as much conscious consideration of the safeguards discussed by Dr. Lewis and his colleagues. Moreover, pediatricians discuss with parents the balance between risk and benefit whenever diagnostic tests and therapeutic procedures are proposed.

"Informed consent in pediatric research" should be viewed as a very old and familiar issue. Unless this is emphasized, there is a real danger that it will grow into a bug-a-hoo which will paralyze efforts to improve the lot of children by properly safeguarded human studies.

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Chief, Perinatology Section
Children's Hospital of San Francisco

LIVINGSTONE, et al.: *Some unanswered questions*

On the basis of their experience at the Beth Israel Hospital in Boston, the authors of "Comprehensive Child Psychiatry Through a Team Approach" have given us working principles that are readily confirmed by the reader's experience. [John B. Livingstone, Tikvah Portnoi, Norman Sherry, Elijahu Rosenheim, and Silvio Onesti, Jr., *CHILDREN*, September-October 1969.] Certainly if a child is in trouble, he needs prompt attention, not an appointment in 3 to 5 months. Certainly if the evaluation of an illness is to be comprehensive, the evaluative team should reserve a place for the pediatrician. And certainly if more than one professional person is entering into the child's problem, they need to be in good communication.

From this article I have the impression of a team with the potential for taking us a good deal further in our thinking about team practice than the authors have done. The team's capacities and resources, as well as its avowed commitment to study, place it in a strategic position to help answer questions about team practice that plague the field. For example, the team approach is practiced characteristically where professional people are on salaries, whereas solo practice supple-

mented by consultation is typical where professional income is determined by fees. Is the consultation method a function of isolation alone?

More should be known about the differences in outcome of these two major methods of helping children in trouble, to determine which is the most effective.

Another contribution to understanding team practice is one the Beth Israel team seems already prepared to make: to illustrate the unique contribution to the team's thinking and operation from the group itself—the product of group processes. When the team comes together, what happens that goes beyond the exercise of individual knowledge and skill adequately communicated? Are the observations of one member sparked or sharpened by those of another? Does diagnostic thinking pyramid and become enriched thereby? Does interaction generate a higher level of creativity than individual parcels collected together? Could the Beth Israel team illustrate from its conferences the presence or absence of a special component that is the product of the group?

Leone Renn

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HAGBERG: *Using the group*

I agree with Katherine Hagberg that both casework and group work methods are useful in helping children cope with a hospital experience. ("Combining Social Casework and Group Work Methods in a Children's Hospital," *CHILDREN*, September-October 1969.) I should like, however, to comment on her statement: "Nevertheless, controlling a group as a possessive child giggles, dances, and fights out his point of view can be arduous for the social worker."

Caseworkers often express this fear of not being able to "control" a group, forgetting that the group itself should be the tool for modifying behavior and for solving problems. For example, a 10-year-old boy, admitted to the pediatric division of our hospital for the last stages of a cleft lip and palate repair, refused to talk. In the group, the other children demanded that he talk, saying that it was easier for them to understand his speech than it was to read his mind.

A group of preadolescent girls were very angry at one member who per-

sisted in telling them frightening stories just as they were settling down for the night. With the help of a group worker, the girls quickly realized that the frightening stories grew out of the girl's own fears about sleeping in the strange setting. The members could accept these feelings; they themselves had them. What they refused to accept was her behavior. They then worked with the storyteller on more effective ways of coping with these common fears.

In both instances, the group was successful in modifying behavior in a positive way in a very brief time.

The group work method can be very effective in a hospital setting but it is certainly no cure-all. As Miss Hagberg points out, there are many instances where casework is indicated. For example, a teenage boy was admitted to the emergency room unconscious, with a punctured bladder. A temporary colostomy was performed on him, and he was brought to our adolescent unit. On regaining consciousness, he was a hostile, uncooperative patient, immobilized with fears and fantasies about being damaged sexually. He refused to communicate with nurses, doctors, and patients. However, in individual casework therapy, he gradually learned to trust the worker, who helped him sort out reality and fantasy and kept him prepared for the many procedures and treatments he had to undergo before he was ready for discharge.

I hope with the author that more and more agencies and institutions using social workers will have both methods available. The choice of the method can then be based on the particular needs of the person and his problem.

Anna Bond

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collected readings

CHILDREN'S BEHAVIOR. Rita E. Bergman, editor. Exposition Press, Inc., 50 Jericho Turnpike, Jericho, N.Y. 11753. 1969. 436 pp. \$12.50.

ISSUES IN ADOLESCENT PSYCHOLOGY. Edited by Dorothy Rogers. Appleton-Century-Crofts, Ed-

ucational Division, Meredith Corp., 440 Park Avenue South, New York, N.Y. 10016. 1969. 614 pp. \$5.50.

READINGS IN SOCIAL DEVELOPMENT. Edited by Ross D. Parke. Holt, Rinehart & Winston, Inc., 383 Madison Avenue, New York, N.Y. 10017. 1969. 605 pp. \$8.95.

MASSIVE PSYCHIC TRAUMA Edited by Henry Krystal, M.D. International Universities Press, 239 Park Avenue South, New York, N.Y. 10003. 1969. 369 pp. \$10.

SOURCEBOOK ON PROBATION, PAROLE AND PARDONS. Third Edition. Charles L. Newman. Charles C Thomas, 301-327 East Lawrence Avenue, Springfield, Ill. 62703. 1968. 469 pp. \$14.75.

EXCEPTIONAL INFANT: the normal infant. Volume 1. Jerome Hellmuth editor. Special Child Publications 4535 Union Bay Place NE., Seattle Wash. 98105. 1968. 568 pp. \$12.50.

DISADVANTAGED CHILD: Head Start and early intervention. Volume 2. Jerome Hellmuth, editor. Brunner Mazel, Inc., 80 East 11th Street, New York, N.Y. 10003. 1969. 621 pp. \$12.50.

TRAUMA, GROWTH AND PERSONALITY. Phyllis Greenacre M.D. International Universities Press, 239 Park Avenue South, New York, N.Y. 10003. 1969. 328 pp. \$7.50.

PSYCHOTHERAPEUTIC AGENTS new roles for nonprofessionals parents, and teachers. Edited with commentaries by Bernard G. Gerner Jr. Holt, Rinehart & Winston, Inc. 383 Madison Avenue, New York, N.Y. 10017. 1969. 595 pp. \$9.95.

BEHAVIORAL IMPLICATIONS FOR CURRICULUM AND TEACHING interdisciplinary readings. Edited by Robert G. Brown, Ronald A. Newell and Herman G. Vonk. William C Brown Book Co., 135 S. Locust Street Dubuque, Iowa 52001. 1969. 264 pp. \$6.50 (paperback).

U.S. Government Publications

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HEW refers to Department of Health, Education, and Welfare; SRS, to Social and Rehabilitation Service; PHS, to Public Health Service; NIH, to National Institutes of Health.

FOOD FOR YOUR BABY'S FIRST YEAR; FOODS FOR THE PRE-SCHOOL CHILD—AGES 13 MONTHS TO 6 YEARS; and EVAPORATED MILK—A GOOD FORMULA FOR BABIES: SINGLE BOTTLE METHOD; A DAY'S SUPPLY THAT WON'T SOUR; and HEATING AFTER BOTTLING. HEW, SRS, Children's Bureau. 1969. 5 cents each.

Five illustrated, simply written leaflets for parents explaining the kinds of foods needed for healthy growth in early childhood, and how they can be prepared.

AMERICANS VOLUNTEER. Department of Labor, Manpower Administration. Manpower/Automation Research Monograph No. 10. 1969. 43 pp. 50 cents.

Reports the results of a nationwide survey of volunteer workers in organizations providing health, education, recreation, and social services to learn how and to what extent their activities supplement the work of paid employees. The findings indicate that while the more schooling and income a person has the more likely he is to engage in

volunteer work, agencies are increasingly looking to low-income people as a source for volunteer help. A concluding chapter raises some unanswered questions: Are wage rates of low-paid jobs depressed by competition from unpaid help? Will increased opportunities for part-time employment in service occupations dry up the source of women volunteers?

THE ACQUISITION AND DEVELOPMENT OF VALUES: perspectives on research; report of a conference, May 15-17, 1968, Washington, D.C. HEW, PHS, NIH, National Institute of Child Health and Human Development. 1969. 65 pp. Single copies free from the Institute.

Reports on a multidisciplinary conference which undertook to examine the influences on the development and nature of moral principles in today's complex, changing society. Among the various points suggested were: that the conflict between materialistic and humanistic values in our society today is not so much a conflict of generations as of segments of society—the young activists tend to be the children of humanist parents; that society is tend-

ing to generate a "protean man" whose values change according to the situation with which the child is confronted; that the validity of specific principles such as "honesty" or "justice" can be judged only on the basis of the psychological, historical, and social context of the conduct being assessed.

STATISTICS ON PUBLIC INSTITUTIONS FOR DELINQUENT CHILDREN, 1967. HEW, SRS, Children's Bureau. CB Statistical Series No. 94. 1969. 13 pp. Single copies free from the Bureau.

Includes a summary and nine tables containing data for each State on the number of children living in public institutions for delinquents and on the number, capacity, occupancy, personnel, and operating expenditure of the institutions as of June 30, 1967. According to the statistics, about 53,000 children were living in institutions for delinquents in 1967—an increase of 4 percent over 1966.

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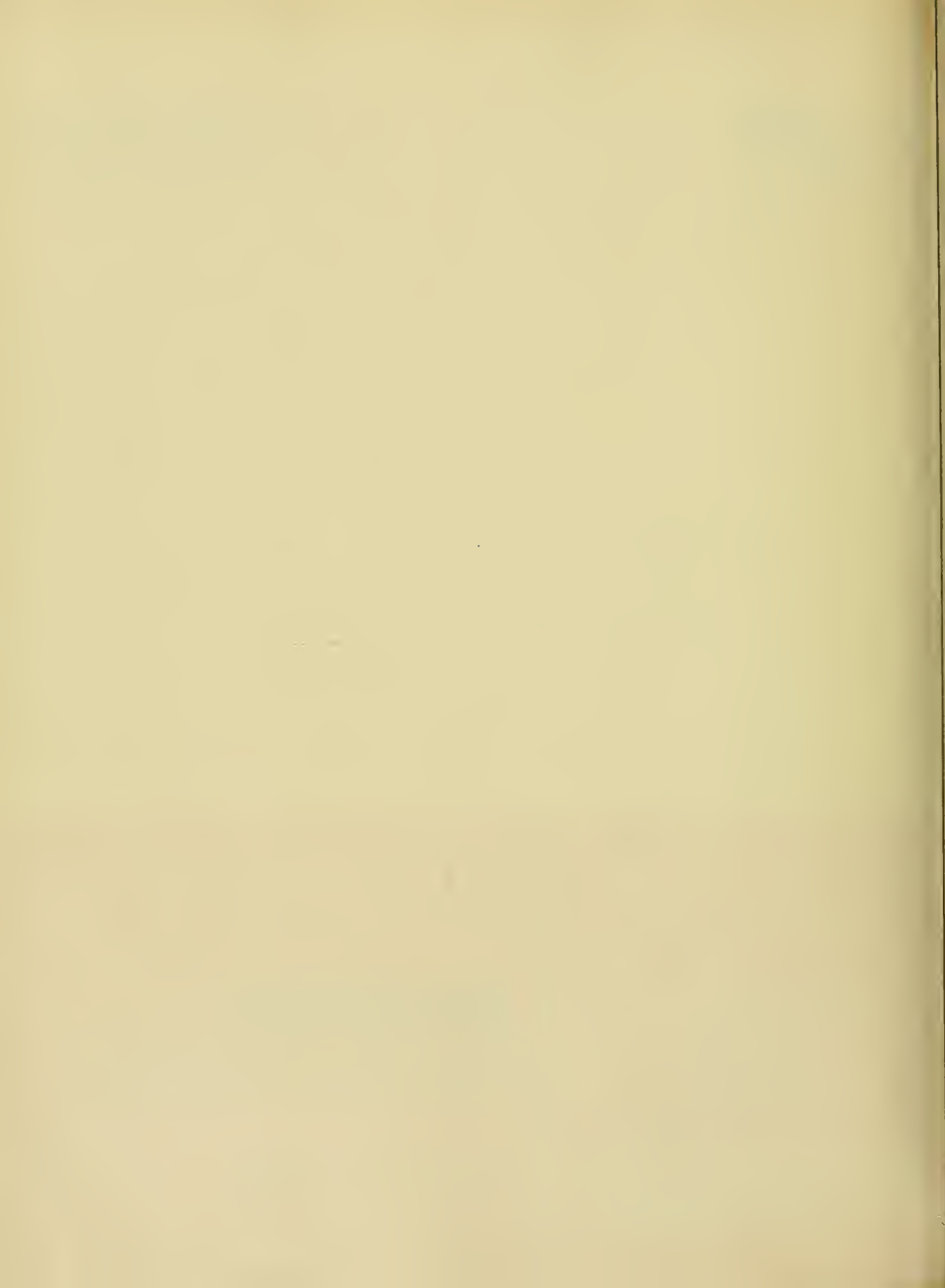
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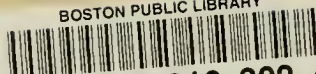
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